Supreme Court, U.S.
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No. _____

In the Supreme Court of the United States

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,
Petitioner,

v.

DAVID C. COOPER,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

1. Whether ERISA continues to govern ongoing claims for ERISA benefits by former employees on post-employment insurance policies derived from the employer's ERISA Plan?

2. Whether the continued existence of an ERISA Plan is a condition precedent to ERISA preemption of ongoing claims for ERISA benefits on post-employment insurance policies derived from the ERISA Plan?

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

Petitioner is Provident Life and Accident Insurance Company, a stock corporation with its principal place of business in Chattanooga, Tennessee. Respondent is David C. Cooper, a married man and resident of the State of Arizona.

UNUMProvident Corporation owns 85.9% of Petitioner Provident Life and Accident Insurance Company. The Paul Revere Life Insurance Company owns 10.1% of Petitioner Provident Life and Accident Insurance Company. UNUM Life Insurance Company of America owns 4% of Petitioner Provident Life and Accident Insurance Company.

Petitioner Provident Life and Accident Insurance Company is hereafter designated as "Provident".

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PETITION FOR A WRIT OF CERTIORARI

Provident respectfully petitions for a Writ of Certiorari to review the Memorandum Decision of the United States Court of Appeals for the Ninth Circuit (hereafter designated the "Ninth Circuit").

OPINIONS BELOW

On May 8, 2002, the Ninth Circuit issued its Memorandum Decision, reversing and remanding the District Court's ERISA preemption ruling, reprinted in the Appendix hereto (App. 3a-4a). On June 21, 2002, the Ninth Circuit issued its Order, denying Provident's Petition for Rehearing and Petition for Rehearing En Banc, reprinted in the Appendix hereto (App. 1a-2a).

STATEMENT OF JURISDICTION

The Ninth Circuit issued its Memorandum Decision on May 8, 2002. The Ninth Circuit denied Provident's timely Petition for Rehearing and Petition for Rehearing En Banc by Order dated June 21, 2002. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED IN CASE

This case involves the interpretation and application of three fundamental statutory provisions of ERISA:

1. 29 U.S.C. § 1002(1) defines "employee welfare benefit plan" and "welfare plan" to include in relevant part:

any plan, fund or program which **was** heretofore or **is** hereafter **established or maintained** by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program **was established or is maintained** for the purpose of providing for its participants or their beneficiaries...(A)...benefits in the event of ...disability...(emphasis added).

2. 29 U.S.C. § 1144(a) is ERISA's supersedure provision, which provides in relevant part:

> [T]he provision of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to **any** employee benefit plan...(emphasis added).

3. 29 U.S.C. § 1002(7) defines a "participant" in an ERISA Plan to include in relevant part:

> any employee **or former employee** of an employer...who is or may be eligible to receive a benefit of any type from an employee benefit plan (emphasis added).

STATEMENT OF THE CASE

I. The Relevant Material Proceedings

On August 1, 1997, Mr. Cooper filed an action against Provident in the District Court arising out of Provident's denial of his claim for total disability benefits, asserting state law contract claims and tort claims of bad faith and punitive damages.

On October 2, 1997, Provident filed its Answer to Mr. Cooper's Complaint, asserting, among other things, that the disability income insurance policy issued in Mr. Cooper's name as part of the Capin Mercantile Corporation Risk Group No. 00072325 constituted an employee welfare benefit plan governed by ERISA, and that Mr. Cooper's state law contract claims and tort claims of bad faith and punitive damages therefore were preempted by ERISA as a matter of law.

On August 28, 1998, the District Court entered its Order granting Provident's Motion for Summary Judgment on the ERISA preemption issue, and dismissing Mr. Cooper's Complaint without prejudice to file an ERISA enforcement action (App. 31a-48a).

On September 25, 1998, Mr. Cooper filed a First Amended Complaint, asserting a claim for ERISA benefits going back to March 1993.

On January 29, 2001, the District Court presided over the ERISA bench trial in this action.

On March 29, 2001, pursuant to Rule 52, Federal Rules of Civil Procedure, the District Court entered its Findings of Fact, Conclusions of Law, and Judgment on the underlying total disability issue, concluding that the evidence was so overwhelming that it was a matter of common sense that Mr. Cooper was never entitled to total disability benefits under the ERISA Plan:

> Accordingly, **common sense dictates** a finding that [Mr. Cooper] was **never** totally disabled within the terms of the policy and **not entitled** to an award of benefits (emphasis added)(App. 29a).

On April 27, 2001, Mr. Cooper timely filed his notice of appeal from the District Court's Judgment, thereby vesting the Ninth Circuit with appellate jurisdiction pursuant to 28 U.S.C. § 1291.

On May 8, 2002, the Ninth Circuit issued its Memorandum Decision reversing and remanding the District Court's ERISA preemption decision (App. 3a-4a).

On June 21, 2002, the Ninth Circuit denied Provident's timely Petition for Rehearing and Petition for Rehearing En Banc (App. 1a-2a).

II. The Relevant Material Facts

The relevant material facts for the Court's consideration are included in the District Court's Rule 52 Findings of Fact dated March 29, 2001 (App. 5a-30a). These facts therefore constitute compelling evidence in support of Provident's Petition given the applicable standard of review that the Ninth Circuit erroneously failed to apply: reviewing the District Court's underlying factual determinations only for clear error, and being bound by those factual determinations unless they are clearly erroneous. *L.K. Comstock & Company v. United Engineers & Constructors, Inc.*, 880 F.2d 219, 221 (9th Cir. 1989); *InterPetrol Bermuda, Ltd. v. Kaiser Aluminum International Corporation*, 719 F.2d 992, 998 (9th Cir. 1983).

On April 18, 1989, Mr. Cooper was the named insured under a disability income policy issued by Provident as part of the Capin Mercantile Corporation ERISA Plan (App. 9a). The Capin ERISA Plan contained a 365-day Elimination Period, which is the number of days a disability must exist before benefits become payable (App. 9a).

In September 1995, Mr. Cooper filed his first claim for ERISA benefits on the Capin ERISA Plan, alleging that his total disability commenced on March 9, 1993, and that he therefore was entitled to ERISA benefits as of March 1994 (App. 10a).

The Capin ERISA Plan terminated in November 1995 when Capin Mercantile Corporation was sold in lieu of filing bankruptcy (App. 8a). Mr. Cooper thereafter elected to continue coverage by making the premium payments himself (App. 43a).

In December 1996, Mr. Cooper filed his second claim for ERISA benefits on the Capin ERISA Plan, alleging once again that his total disability commenced on March 9, 1993 and that he therefore was entitled to ERISA benefits as of March 1994 (App. 10a). Provident treated Mr. Cooper's second claim as a request to reopen his first claim (App. 10a).

REASONS FOR GRANTING THE PETITION

I. The Ninth Circuit Has Entered A Decision Which Conflicts With The Decisions Of The Sixth, Eighth and Eleventh Circuits.

ERISA is a federal statute of national application in which there is an overriding need for national uniformity. This Court has repeatedly recognized this fundamental principle of ERISA law, and has done so as recently as a few months ago. *Rush Prudential HMO, Inc. v. Moran*, ___ U.S. ___, No. 00-1021 (June 20, 2002); *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41 (1987).

Now, however, the Ninth Circuit has issued a Memorandum Decision, predicated exclusively upon its

earlier aberrant Decision in *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001), which conflicts with the Decisions of the Sixth, Eighth and Eleventh Circuits. Consequently, there now is an alarming and significant conflict among the Circuits as to whether ERISA continues to govern ongoing claims for ERISA benefits by former employees on post-employment insurance policies derived from their employer's ERISA Plan.

This Court therefore should grant Provident's Petition, vacate the Ninth Circuit's Memorandum Decision and aberrant Decision in *Waks*, *supra*, and restore crucial national uniformity to ERISA's application among all the Circuits throughout the United States.

In *Massachusetts Casualty Insurance Company v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997), the plaintiff was one of five or six employees who participated in his employer's ERISA plan for disability insurance benefits via the issuance of individual policies, exactly like the Capin ERISA Plan that Mr. Cooper participated in here. When the plaintiff left his employer, he assumed the premium payments on his individual policy and it therefore remained in force without change, exactly like Mr. Cooper did here. The Sixth Circuit held that ERISA still governed the plaintiff's post-employment claims on that policy. *Reynolds*, *supra* at 1453.

Indeed, the Ninth Circuit in *Waks*, *supra*, expressly distinguished Mr. Reynolds from Mrs. Waks, stating that Mr. Reynolds remained subject to ERISA because he had merely assumed the premium payments on the identical individual disability income policy, rather than exercised a formal ERISA conversion right. *Waks*, *supra* at 878. This is exactly what Mr. Cooper did here, which emphatically demonstrates how the Ninth Circuit's Memorandum Decision conflicts not

only with Sixth Circuit's Decision, but also with the Ninth Circuit's own Decision in *Waks*, *supra*.

In *Painter v. Golden Rule Insurance Company*, 121 F.3d 436 (8th Cir. 1997), the plaintiff was a participant in her employer's ERISA plan for health insurance benefits. **After her employer terminated the entire ERISA plan**, the plaintiff obtained a health insurance conversion policy. The Eighth Circuit held that ERISA governed the conversion policy **even though the employer had terminated the entire ERISA plan** because the conversion policy "came into being as a result of" the employer's ERISA plan "which gave [it] birth." *Painter*, *supra* at 439-440.

The Eighth Circuit reached its decision by employing the identical analysis of ERISA as Provident employed in the Ninth Circuit:

> **We conclude that [the plaintiff's] claim for benefits under the conversion policy is governed by ERISA.** The issue turns on three statutory provisions. First, the ERISA provision governing claims for plan benefits, 29 U.S.C. **§ 1132(a)(1)(B)**, provides that an ERISA "**participant**" may sue "to recover benefits due to him under the terms of his plan." Second, the definition of "participant" in 29 U.S.C. **§ 1002(7)** includes "any employee **or former employee** [emphasis in original] of an employer...who is or may become eligible to receive a benefit of any type from an employee benefit plan." **In other words, a former employee such as [the plaintiff] may be an ERISA participant**

> **entitled to sue for benefits under § 1132(a)(1)(B)** (emphasis added).

Painter, *supra* at 439.

The Eighth Circuit continued with its identical analysis of ERISA by reviewing the definition of an "employee welfare benefit plan" set forth in § 1002(1), just as Provident did in the Ninth Circuit:

> That leaves the question whether [the plaintiff's] conversion policy benefits are "due [her] under the terms of [her] plan" within the meaning of **§ 1132(a)(1)(B)**. ERISA defines an "employee welfare benefit plan", such as [the employer's] group health plan, to mean "any plan, fund, or program...**established or maintained** by an employer...for the purpose of providing for its participants...(A) medical, surgical, or hospital care or benefits." 29 U.S.C. **§ 1002(1)**....A suit to recover benefits due [the plaintiff] under that group policy, **including continuation benefits due her as a former employee**, would be governed by § 1132(a)(1)(B) (emphasis added).

Painter, *supra* at 439.

As noted above, the Eighth Circuit concluded that ERISA governed the conversion policy **even though the employer had terminated the entire ERISA plan** because the conversion policy "came into being as a result of" the employer's ERISA plan "which gave [it] birth." *Painter*, *supra* at 439-440. In essence, the Eight Circuit applied the same type of "derived from" test for ERISA preemption that

had long been the law throughout the Ninth Circuit, until this particular panel issued its aberrant Decisions here and in *Waks*, *supra*:

> Here, of course, **the group policy has expired**, and [the plaintiff] is seeking medical benefits under [the insurer's] separate conversion policy. **But the conversion policy came into being as a result of [the plaintiff] exercising her right under the group policy to obtain this specific insurance policy.** Thus, the right to a conversion policy was part of the plan or program **"established"** by [the employer] to provide medical benefits for its current and former employees. As such, the conversion policy is a component of [the employer's] ERISA plan. **A suit to recover conversion policy benefits is governed by § 1132 (a)(1)(B)** (emphasis added).

Painter, *supra* at 439-440.

It is important to recognize that the Eighth Circuit applied–just as Provident applied in the Ninth Circuit–the past tense "was established" provisions of § 1002(1) to an employer's ERISA plan that no longer existed, and yet reached the exact same conclusion that the Ninth Circuit had repeatedly reached using the "derived from" test in *Peterson v. American Life & Health Insurance Company*, 48 F.3d 404, 408 (9th Cir. 1995); *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839, 843 n.4 (9th Cir. 1994); *Greany v. Western Farm Bureau Life Insurance Company*, 973 F.2d 812, 817 (9th Cir. 1992); *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124, 1132-1133 (9th Cir. 1992), none of which were overruled by the Ninth Circuit in *Waks*, *supra*, and the

fundamental principle of which was affirmed by the Ninth Circuit in its *en banc* decision in *Kearney*, *infra*, where the Ninth Circuit expressly held that ERISA continued to govern an ongoing claim for ERISA benefits on a terminated ERISA Plan.

The Eighth Circuit even cited to the Ninth Circuit's decisions in *Peterson* and *Greany* as authority for its ruling:

> Because [the plaintiff's] underlying claim for conversion policy benefits is governed by ERISA, her state law claims for [the insurer's] alleged mishandling of that claim are preempted under *Pilot Life*. **This conclusion is consistent with the overwhelming majority of preemption decisions involving conversion policies and the ERISA plans which gave them birth**, [citing *Peterson*, *Greany*, and *Reynolds*] (emphasis added).

Painter, *supra* at 440.

Finally, the Ninth Circuit's Memorandum Decision also conflicts with the Eleventh Circuit's decision in *Glass v. United of Omaha Life Insurance Company*, 33 F.3d 1341, 1347 (11th Cir. 1994), wherein the Eleventh Circuit held that "conversion of the [life insurance] coverage did not defeat ERISA regulation."

The Ninth Circuit's Memorandum Decision creates a significant conflict among the Circuits regarding how and when ERISA applies to post-employment insurance policies derived from ERISA Plans. This conflict with the Sixth, Eighth and Eleventh Circuits substantially and deleteriously affects the national uniformity with which ERISA must be

applied, and cries out for this Court's review and restoration of this crucial national uniformity among all the Circuits. Provident's Petition for a Writ of Certiorari therefore should be granted at this time.

II. The Ninth Circuit Has Entered A Decision Which Conflicts With The Express Provisions Of ERISA And With The Decisions Of This Court Interpreting And Applying ERISA.

By erroneously concluding that the continued existence of the Capin ERISA Plan was a condition precedent to ERISA preemption, the Ninth Circuit issued a Memorandum Decision which directly conflicts with the express provisions of ERISA and with the Decisions of this Court, because the fact that Mr. Cooper's employer went out of business does not change the fundamental ERISA analysis.

In § 1002(1) of ERISA, the U.S. Congress defines "employee welfare benefit plan" and "welfare plan" to include:

> any plan, fund or program which **was** heretofore or **is** hereafter **established or maintained** by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program **was established or is maintained** for the purpose of providing for its participants or their beneficiaries...(A)...benefits in the event of ...disability...(emphasis added).

The express provisions of § 1002(1) clearly demonstrate that the U.S. Congress intended ERISA to govern every type of ERISA plan that either once "**was** established"

or still "**is** maintained" by an employer. The change from past tense to present tense in such an unambiguous manner, and the use of the disjunctive "or" rather than the conjunctive "and", readily demonstrate that the U.S. Congress intended ERISA to govern all claims for benefits derived from any type of ERISA plan that once "**was** established" by an employer, regardless of whether the ERISA plan continued to exist until the time of an insured's claim.

In addition, the express provisions of 29 U.S.C. § 1144(a) clearly demonstrate that the U.S. Congress intended ERISA to "supersede any and all State laws insofar as they may now or hereafter relate to **any** employee benefit plan", regardless of whether the ERISA plan continued to exist until the time of an insured's claim.

The Ninth Circuit's apparent belief that Mr. Cooper's post-employment policy did not "relate to" the Capin ERISA Plan is fundamentally flawed because Mr. Cooper would have no relationship with Provident and no cause of action against Provident without the Capin ERISA Plan initially selected and established by Capin for the welfare and benefit of its employees. Indeed, Mr. Cooper could not have independently subscribed to Provident for the same disability insurance coverage at the same discounted premium rates he received through Capin as a benefit of employment at Capin. Furthermore, Mr. Cooper's continuing eligibility to obtain the same disability insurance coverage at the same discounted premium rates even after Capin terminated the entire Plan–without having to undergo an additional medical examination, provide proof of good health, or be subjected to updated pre-existing conditions exclusions–was based solely upon his previous employment at Capin and his prior status as a covered employee belonging to the class of beneficiaries covered by the Plan.

In addition, the express provisions of 29 U.S.C. § 1002(7) further demonstrate that the U.S. Congress intended ERISA to continue to apply to all post-employment claims for ERISA benefits on policies derived from an ERISA Plan, regardless of whether the ERISA Plan continued to exist. This section defines a "participant" in an ERISA plan to include:

> any employee **or former employee** of an employer...who is or may be eligible to receive a benefit of any type from an employee benefit plan (emphasis added).

The only way a former employee could assert such a claim for benefits is if he had formally converted his ERISA plan benefits into an individual policy, or, like Mr. Cooper, had merely elected to continue coverage by paying the premiums himself upon termination of his employment. Therefore, the U.S. Congress clearly contemplated the filing of claims for ERISA benefits by former employees on their post-employment policies derived from their employer's ERISA Plan, by formal conversion or by mere election of continued coverage, regardless of whether the employer's ERISA Plan continued to exist until the time of the former employee's claim.

According to the Ninth Circuit's Memorandum Decision, however, ERISA would authorize former employees with post-employment policies derived from their employer's ERISA Plan to avail themselves of the civil enforcement provisions of § 1132, but the same former employees would not be subject to the preemptive provisions of § 1144. This inherent contradiction eviscerates the national uniformity of application required by ERISA, highlights the fundamental flaw within the *Waks* decision (because Mrs.

Waks was a former employee and therefore was an ERISA Plan "participant" as a matter of law) and the Ninth Circuit's exclusive reliance upon it here, and clearly warrants the granting of Provident's Petition for a Writ of Certiorari.

This Court has repeatedly recognized that ERISA specifically includes former employees within its definition of ERISA Plan "participants":

> In sum, the detailed provisions of § 502(a) set forth a comprehensive enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if **ERISA-plan participants and beneficiaries** were free to obtain remedies under state law that Congress rejected in ERISA (emphasis added).

Pilot Life, supra at 54.

Furthermore, this Court has specifically recognized that ERISA Plan participants–i.e. former employees–are subject to ERISA with regard to all lawsuits brought by them for ERISA benefits:

> Congress' specific reference to § 301 of the LMRA to describe the civil enforcement scheme of ERISA makes clear its intention that **all suits brought by beneficiaries or participants** asserting improper processing of

> claims under ERISA-regulated plans be treated as federal questions governed by § 502(a) (emphasis added).

Pilot Life, supra at 56. *See also, Rush Prudential, supra*, where this Court held that state laws providing an ERISA Plan participant with an "additional claim or remedy" would "patently violate ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred", citing *Pilot Life, supra* at 56.

Furthermore, this Court can and should take judicial notice of the multitude of provisions of ERISA which specifically govern the termination of certain ERISA plans and which further demonstrate that the U.S. Congress clearly contemplated former employees making claims for benefits on post-employment policies derived from terminated ERISA plans. See 29 U.S.C. §§ 1001(a), 1001(b), 1341, 1342.

Indeed, in *Waller v. Blue Cross of California*, 32 F.3d 1337, 1343 (9th Cir. 1994), the Ninth Circuit held that when ERISA pension plans terminate, both ERISA Title I fiduciary standards and ERISA Title IV termination requirements are applicable and must be followed.

In its Memorandum Decision, and in *Waks, supra*, the Ninth Circuit did not cite to any provision within ERISA that required the continued existence of the ERISA Plan in order for ERISA to continue to apply to claims on policies which insureds like Mr. Cooper elect to keep in force by paying the premiums themselves after employment. In fact, the provisions of ERISA clearly state that ERISA continues to

apply in these circumstances. *See* 29 U.S.C. §§ 1002(1); 1002(7); 1144(a).

This Court has repeatedly recognized the necessity of national uniformity of ERISA's application:

> [T]he basic thrust of the preemption clause is to avoid a multiplicity of regulation in order to permit the **nationally uniform administration** of employee benefit plans....[T]he principal object of [ERISA] is to protect plan participants and beneficiaries (emphasis added).

New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company, 514 U.S. 645, 657 (1995); *Boggs v. Boggs*, 520 U.S. 833, 845 (1997).

Provident's Petition for a Writ of Certiorari therefore should be granted to restore crucial national uniformity to ERISA's application within the Ninth Circuit and among all the Circuits throughout the United States, consistent with the express provisions of ERISA itself. *See* 29 U.S.C. § 1001(b)(ERISA Plans are "affected with a national interest").

III. The Ninth Circuit Has Entered A Decision Which Conflicts With Its Own Reported Decisions.

The Ninth Circuit predicated its Memorandum Decision exclusively upon the material point of law that Mr. Cooper's appeal was controlled by *Waks, supra*, because "there was no ERISA Plan after [Capin] ceased doing business and Cooper continued independently to make full payment of premiums" (App. 4a).

There is, however, no provision, express or implied, within ERISA that requires the continued existence of the ERISA Plan in order for ERISA to continue to apply to claims on policies which insureds like Mr. Cooper elect to keep in force by paying the premiums themselves after employment.

The Ninth Circuit's misstatement of this material point of law contradicts this fundamental principle of ERISA law, and also conflicts with the Ninth Circuit's own published *en banc* decision in *Kearney v. Standard Insurance Company*, 175 F. 3d 1084, 1096, n. 1 (9th Cir. 1999), *cert. denied*, 120 S.Ct. 398 (1999), where the Ninth Circuit conducted an exhaustive ERISA analysis and held that ERISA continued to apply to the insured's ongoing claim for ERISA benefits even though the insured's employer was no longer in business and the ERISA plan no longer existed. This is exactly what the Eighth Circuit held in *Painter, supra*, but this particular panel ignored its own *en banc* precedent in *Kearney, supra*, as well as the compelling *Painter* precedent from the Eighth Circuit, thereby exacerbating the conflict among the Circuits that its prior aberrant Decision in *Waks, supra,* had created one year earlier.

In addition, the Ninth Circuit also concluded that its decision in *Waks, supra*, controlled Mr. Cooper's appeal in part because "Cooper continued independently to make full payment of premiums" after the Capin ERISA Plan terminated in November 1995, thereby distinguishing Mr. Cooper from an insured who formally exercises an ERISA conversion right and obtains a new and different conversion policy (App. 4a).

However, in *Waks, supra*, when the Ninth Circuit distinguished between these two kinds of insureds, the Ninth Circuit expressly held that an insured like Mr. Cooper who merely elects to continue coverage under the same policy by

making the premium payments himself is still subject to ERISA, but that an insured unlike Mr. Cooper who formally exercises his ERISA conversion rights and later makes a claim on a new, separate, converted individual policy is not subject to ERISA. *Waks, supra* at 875-876, 878, distinguishing *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839 (9th Cir. 1994) and *Massachusetts Casualty Insurance Company v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997). The panel's Memorandum Decision therefore conflicts with the very precedent upon which it exclusively predicated its Decision.

In its Memorandum Decision, the Ninth Circuit erroneously characterized Mr. Cooper's post-employment insurance policy as a simple private policy unrelated to the very ERISA Plan from which it was derived. The panel's rationale conflicts with the Ninth Circuit's own Decisions in *Peterson, Greany, Qualls*, and *Tingey, supra*, wherein the Ninth Circuit repeatedly affirmed the "derived from" test as the determinative test for ERISA preemption of state law claims on post-employment insurance policies.

In fact, in *Qualls, supra*, the Ninth Circuit summarily rejected the very rationale invoked by the panel here:

> Mr. Qualls also argues, in his reply brief, that the policy was not covered by ERISA because once he was no longer employed at Saddleback his continued coverage was based on a **simple private policy, unrelated to employment**.... **This argument fails to take note of the fact that Mr. Quall's continuing eligibility was based solely on his previous employment at Saddleback. If the policy was governed by ERISA when he was at Saddleback, it**

> **continued to be governed by ERISA once he left**, citing *Tingey, supra* (emphasis added).

Qualls, supra at 843, n.4.

Moreover, by characterizing Mr. Cooper's post-employment insurance policy as a simple private policy unrelated to his prior employment, the panel ignored numerous crucial facts which the Ninth Circuit in *Greany, supra*, held were dispositive of the ERISA preemption issue and the "derived from" test:

> No conversion benefits would be available **unless the party seeking the conversion policy was an eligible insured beneficiary of a group plan**....Because the Greanys would not be eligible for a conversion policy **without first belonging to the class of beneficiaries covered by the ERISA group plan**, we conclude that the individual conversion benefits are part of the ERISA plan and are thus governed by ERISA....**Despite the Greanys' attempts to recharacterize their relationship with [the insurer] to create a duty independent of the group plan, "[t]here would be no relationship or cause of action...without the plan"** (emphasis added and citation omitted).

Greany, supra at 817.

The panel's erroneous attempt to recharacterize Mr. Cooper's relationship with Provident to create a duty independent of the Capin ERISA Plan remains as fundamentally flawed as it was in *Waks, supra*, because Mr.

Cooper would have no relationship with Provident and no cause of action against Provident without the ERISA Plan initially selected and established by Capin for the welfare and benefit of its employees. *Greany, Qualls, supra.*

Consequently, the granting of Provident's Petition for a Writ of Certiorari is necessary and appropriate to restore crucial national uniformity to ERISA's application within the Ninth Circuit and among all the Circuits throughout the United States.

IV. The Ninth Circuit Has Entered A Decision Which Conflicts With The Rule 52 Findings Of Fact Of The District Court.

The Ninth Circuit predicated its Memorandum Decision exclusively upon the material point of fact that "Any ERISA Plan that did exist during Cooper's employment was terminated when the employer went out of business and before Cooper filed his claim" (App. 4a).

The Ninth Circuit's misstatement of this material point of fact contradicts the Rule 52 Findings of Fact by the District Court that Mr. Cooper had filed his claim for ERISA benefits on the Capin ERISA Plan **two months before** the Plan terminated, and that Mr. Cooper had sought ERISA benefits all the way back to March 1993, **over 2½ years before** the ERISA Plan terminated (App. 8a, 10a).

By overlooking this material point of fact, the Ninth Circuit erroneously concluded that ERISA did not preempt Mr. Cooper's state law claims. Indeed, it is difficult to imagine how Mr. Cooper's claim could not be governed by ERISA, when he asserted a claim on an existing ERISA Plan for ERISA benefits going all the way back to over 2½ years

before the ERISA Plan even terminated. This is exactly what Mr. Kearney did, which conclusively demonstrates how this particular panel ignored its own *en banc* Decision in *Kearney, supra*, and erroneously perpetuated the conflict with the Sixth, Eighth and Eleventh Circuits by relying exclusively upon its aberrant Decision in *Waks, supra*, which had created the conflict one year earlier.

Consequently, the granting of Provident's Petition for a Writ of Certiorari is necessary and appropriate to restore crucial national uniformity to ERISA's application within the Ninth Circuit and among all the Circuits throughout the United States for this reason as well.

CONCLUSION

The Ninth Circuit's Memorandum Decision perpetuates a significant conflict within the Ninth Circuit and among all the Circuits regarding how and when ERISA applies to post-employment insurance policies derived from ERISA Plans. This conflict with the Sixth, Eighth and Eleventh Circuits, as well as within the Ninth Circuit itself, substantially and deleteriously affects ERISA, which clearly is a rule of national application in which there is an overriding need for national uniformity.

Provident therefore respectfully requests the Court to take judicial notice of its own Rule 10(a), which expressly recognizes such conflicts as a compelling reason for review, and respectfully requests the Court to grant Provident's Petition for a Writ of Certiorari, vacate the Ninth Circuit's Memorandum Decision and *Waks* Decision, and thereby restore crucial national uniformity to ERISA's application within the Ninth Circuit and among all the Circuits throughout the United States.

RESPECTFULLY SUBMITTED,

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 01-15879

[Filed June 21, 2002]

DAVID C. COOPER,
Plaintiff - Appellant,

v.

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, A STOCK CORPORATION,
Defendant - Appellee.

D.C. No. CV-97-00490-JCC
District of Arizona, Tucson

JUDGES:
Before SCHROEDER, Chief Judge, B. FLETCHER and KOZINSKI, Circuit Judges

ORDER

The panel has voted unanimously to deny appellee's petition for rehearing and to deny the petition for rehearing en banc.

The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on the petition for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing and petition for rehearing en banc are DENIED.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 01-15879

[Filed May 8, 2002]

DAVID C. COOPER,
Plaintiff - Appellant,

v.

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, A STOCK CORPORATION,
Defendant - Appellee.

JUDGES:
Before SCHROEDER, Chief Judge, B. FLETCHER and KOZINSKI, Circuit Judges

MEMORANDUM*

David Cooper seeks long term disability benefits. Here he challenges the district court's determination that his policy

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as may be provided by Ninth Circuit Rule 36-3.

was governed by ERISA and that his state law claims against the defendant were therefore preempted. We need not reach his contention that the plan in its original form was within the "safe harbor" defined by the Department of Labor regulation exempting plans to which the employer neither contributed nor endorsed from ERISA coverage. 29 C.F.R. § 2501.3-1(j) (2002). Any ERISA plan that did exist during Cooper's employment was terminated when the employer went out of business and before Cooper filed his claim. Cooper filed the claim under consideration in this case in December 1996 almost a year after the company went out of business.

Accordingly, even if there had been an ERISA plan in existence when the company was still functioning, there was no ERISA plan after it ceased doing business and Cooper continued independently to make full payment of premiums. The case is therefore controlled by our decision in *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 874 (9th Cir. 2001).

The judgment of the district court is reversed and the matter is remanded to permit the appellant to pursue his state law claims.

REVERSED AND REMANDED.

APPENDIX C

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ARIZONA

No. CV-97-490-TUC-JCC

[Filed March 29, 2001]

DAVID C. COOPER,	)
Plaintiff,	)
	)
v.	)
	)
PROVIDENT LIFE & ACCIDENT	)
INSURANCE COMPANY,	)
Defendant.	)

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND JUDGMENT

INTRODUCTION

Plaintiff, David C. Cooper, brings this action to recover total disability benefits under an ERISA[1] disability plan sponsored by his former employer, Capin Mercantile

[1] Employee Retirement Security Act of 1974, 29 U.S.C. § 1001, et seq.

Corporation. Defendant, Provident Life and Accident Insurance Company, is the claims administrator of the policy. Plaintiff argues he is entitled to receive disability benefits and Defendant has continuously denied his claim. This matter came on for a civil bench trial on January 29, 2001. Oral argument on the administrative record was conducted, after which the case was submitted to the Court for decision. Pursuant to Fed. R. Civ. P. 52(a), the Court now makes the following findings of fact and conclusions of law.

The question before the Court is whether Plaintiff, due to surgery and treatments for thyroid cancer, hypothyroidism, lymphedema, urological problems, headaches and chronic fatigue, is totally disabled and precluded from continuing in his occupation as a mercantile buyer due to inability to fulfill a substantial and material duty of his occupation, travel to markets.

JURISDICTION

This Court has jurisdiction under 29 U.S.C. §1132(e) (ERISA). All parties have consented to allow a Magistrate Judge to enter final orders and judgment in this case in accordance with 28 U.S.C. §636(c).

PROCEDURAL BACKGROUND

Plaintiff originally filed this action in an Arizona state court alleging state law violations. On August 1, 1997, Defendant removed the action to the United States District Court for the District of Arizona in Tucson. On April 8, 1998, Defendant filed a Motion for Summary Judgment

alleging that the allegations made by Plaintiff stated a cause of action under ERISA which preempted state law claims. On August 28, 1998, this Court agreed, entered an Order granting Defendant's Motion for Summary Judgment, and granted Plaintiff leave to file an Amended Complaint based on ERISA violations. Plaintiff's Amended Complaint was timely filed. On August 27, 1999, the Court entered an Order resolving that the standard of review was *de novo* and the scope of review was limited to the administrative record. Upon Plaintiff's request to reconsider that Order, the Court again entered an Order on January 19, 2000 ruling that, in this case, ERISA preempts all state law claims, an ERISA bench trial would be limited to the administrative record, and the administrative record should be immediately filed with the Court. The administrative record[2] (AR) was filed with the Court on January 28, 2000.

On May 15, 2000, Defendant filed a Motion for Summary Judgment and on June 22, 2000, Plaintiff filed a Cross-Motion for Partial Summary Judgment. The Court denied both parties' motions for summary judgment and set the matter for a bench trial to commence on January 29, 2001. Both parties filed or lodged proposed Findings of Fact and Conclusions of Law and legal briefs. The civil bench trial consisted of oral argument concerning the administrative record before the plan administrator with no additional witnesses or exhibits.

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[2] Vol. I, Bate-stamped 1-500; Vol. II, Bate-stamped 501-1000; Vol. III, Bate-stamped 1001-1381.

STANDARD OF REVIEW

The standard of review employed in this ERISA case is *de novo* pursuant to this Court's Order entered in July 1999. *See Kearney v. Standard Ins. Co.*, 175 F.3d 1084 (9th Cir.), *cert denied*, 528 U.S. 964 (1999). "When a trial judge reads the administrative record he is asking, whether claimant is disabled within the terms of the policy." *Kearney*, 175 F.3d at 1090. The Court considered only evidence that was part of the administrative record (including the policy at issue) in rendering this decision.

FINDINGS OF FACT

From 1976 through 1995, Plaintiff worked as a merchandise buyer.[3] (AR 827.) In 1992, Plaintiff was the advertising director, merchandise manager and senior buyer for Capin Mercantile Corporation (Capin Mercantile) of Nogales, Arizona and he was a member of the family who owned Capin Mercantile.[4] (AR 825.) In November 1995, Capin Mercantile was sold in lieu of filing for bankruptcy. (AR 252.) The dissolution of the family business created strife between the various extended family members. The time leading up to the dissolution of the family business also

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[3] Plaintiff's birthday is June 17, 1954.

[4] Plaintiff's grandfather started the business. When he retired, Plaintiff's uncles and father took over the business. In 1994, the family business passed to the third generation, Plaintiff and his cousins.

coincided with Plaintiff's battle with cancer. (AR 251-252, 313.)

On April 18, 1989, Plaintiff was the named insured under a disability income policy issued by Defendant as part of the Capin Mercantile ERISA plan.[5] This policy would have provided total disability coverage in the amount of $8,540 per month for Plaintiff. (AR 1350.) The policy specifically states that:

> Total Disability' means that because of Injury or Sickness:
>
> (1) [The insured] cannot perform the substantial and material duties of [his] regular occupation...;
>
> and
>
> (2) [The insured is] receiving care by a Physician which is appropriate for the condition causing [his] disability.

The policy defines the elimination period as the number of days of disability that must elapse in a period of disability before benefits become payable, in this case 365 days. These days need not be consecutive; they can be accumulated during a period of disability to satisfy an elimination period. A notice of claim should be filed within 20 days of disability onset or as soon thereafter as possible.

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[5] The policy is attached as Exhibit A to Defendant's Motion for Summary Judgment. (Doc. Nos. 156, 157.)

Plaintiff filed his first Notice of Claim with Defendant on September 27, 1995. (AR 826, 1379.) He claimed that the onset date of his disability was March 9, 1993, due to surgery and treatment for thyroid cancer. Defendant denied Plaintiff's first claim because: (1) the elimination period of 365 days was not satisfied and (2) the reduction of workload and work activities was the result of job performance, not health. (AR 702-703.) During the bench trial, Defendant explained that the insurance company did not dispute Plaintiff's medical condition, rather the conclusion that he was totally disabled and unemployed due to his health.

Plaintiff filed a Second Notice of Claim in December 1996. (AR 636.) The last day worked was November 15, 1995, but his onset date is still listed as March 9, 1993. A notation in the claim file indicates that Provident was internally treating the second claim as a request to reopen the first claim. (AR 630.) Defendant followed up with requests for new and additional medical evidence. (AR 631.) A formal response to Plaintiff's second claim was sent in June 1997. (AR 568-569.) Defendant did not accept or reject Plaintiff's second claim but has refused to pay any total disability benefits under its insurance contract.

The parties do not dispute that travel was a substantial and material duty of Plaintiff's occupation as a mercantile buyer. When his disability insurance policy was first acquired in 1989, Plaintiff described his position as travel intensive. (AR 119.) In his first Notice of Claim in September 1995, and elsewhere, Plaintiff designated travel as an essential component of his job. (AR 1381, 832, 649-650.)

Plaintiff did not work at all for a total of eight and one half months during the period from March 1993 through September 1995. (AR 1203.) In March 1993, Plaintiff was diagnosed with thyroid cancer. Plaintiff had a thyroidectomy, where the entire thyroid gland was removed.[6] From March 1993 through June 1993, Plaintiff did not work due to thyroid cancer surgery and recuperation from that surgery. From April through June 1994, Plaintiff did not work due to treatment to destroy additional cancer cells, specifically radioactive iodine treatment. From February through April 1995, Plaintiff did not work due to node surgery resulting from lymphedema.[7] From June through July 1995, Plaintiff did not work due to additional lymph node treatment. The Court recognizes and the Defendant does not dispute that Plaintiff had treatment for thyroid cancer, hypothyroidism, lymphedema, urological problems[8] and experienced associated fatigue and concentration difficulties.

Plaintiff's psychologist, Dr. Fox, submitted notes from counseling sessions with Plaintiff from May 1993 through

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[6] Plaintiff will need to take thyroid supplements for the rest of his life. He was also left with a condition called 'hypothyroidism." The symptoms can be: nervousness, insomnia, emotional swings, sweating, tremors, muscle weakness, weight loss.

[7] Lymphedema is an abnormal accumulation of lymph in the spaces between the tissues which produces swelling and inflammation, in Plaintiff's case, his right arm.

[8] Plaintiff was hospitalized with chronic prostatitis from December 1- 6, 1994. (AR 641.)

July 1997. (AR 247-313.) Dr. Fox treated Plaintiff for depression associated with cancer. (AR 447448.) Plaintiff was also depressed about the impending loss of the family business. During the sessions from 1993 - 1997, Plaintiff himself confirmed that he returned to work, resumed his previous work responsibilities and continued to travel. Dr. Fox's ultimate conclusion from December 20, 1995 was: adjustment disorder with mixed emotional features. (AR 247-248.) He found "reactive depression associated with health, family and financial circumstances - fatigue and stamina issues." (AR 249.) Plaintiff was undergoing a time of reflection on May 25, 1993: "Is this (business) what I want to do with the rest of my life. . ."(AR 312.) There was a trip to family reunion in June 1993. (AR 310.) He reported that his energy was returning and he had reassumed authority at work. (AR 309.) In October 29, 1993, Plaintiff reported returning from "whirlwind travel - visit[ing] 8 stores. . . " (AR 304.) He was also taking Prozac for depression. (AR 302.) In June 1994, he was working "12-14 [hours]- 6 days [a] week." (AR 294.) His energy level was up and his mood better; work relationships had improved. (AR 294.) He was aware that he was competing for his position in the family business in July 1994. (AR 293.) In August 1994, Dr. Fox wrote: "A fierce internal struggle for power and control in the family business. He has been sick for 2 years and not performing. This is being used against him as the family realigns the business." (AR 292.) Plaintiff could not decide whether to fight to stay in or fight to get out. (AR 292.) August 1994 was the apex of the family feud and Plaintiff's struggle. (AR 291.) Plaintiff indicated that he was having problems fighting the prostatic infection because his resistance was down due to chemotherapy. (AR 288.) In December 14,

1994, Plaintiff related that his work demotion was depressing. (AR 288.) He was worried his cancer might be coming back. (AR 286.) By April 3, 1995, he had been given his old job back, his health had stabilized and he harbored a fear of starting over. (AR 285.) He was feeling vindicated at work. (AR 284.) In May 1995, he noted having lymphoma but that work was going well. (AR 283.) He noted in July 1995 that he needed to make a career change. (AR 281.) He was cancer free in March 1996. (AR 275.) He was considering opening a coffee house. (AR 274.)

Thyroid cancer and follow-up treatments did not render Plaintiff totally unable to work or travel, nor did the residual hypothyroidism. Plaintiff was diagnosed as cancer-free after surgery and treatment and his hypothyroidism was controlled with medication. Plaintiff submitted letters from Dr. Salmon, oncologist, (AR 1195) and Dr. Insel, endocrinologist. (AR 1194.) Dr. Salmon, Plaintiff's oncologist, wrote a letter in October 1995 stating that Plaintiff was "clinically hypothyroid." (AR 1195.) He was taking Synthoid to regulate his system in place of the thyroid gland. In April 1995, Plaintiff had a completely normal physical exam. (AR 1213.) He was experiencing some fatigue and depression, but better in terms of his mood. (AR 1221.) From November 1993, Dr. Salmon noted that Plaintiff was feeling well and out of the woods for major risk of recurrence. (AR 1245.) Dr. Insel, Plaintiff's endocrinologist, wrote in December 1995 that the "major concern is his fatiguability," based on Plaintiff's complaints to him. (AR 1194.) He noted that "David looks excellent" in June 1995. (AR 1154.) He also noted that "[h]e is actively pursuing some projects in Tubac." (AR 1155.) Dr. Insel noted "fatigue," again based on

Plaintiff's complaints (AR 1155), but ultimately found an "excellent recovery." (AR 1248.) Dr. Insel also noted in January 1994, that "[h]e also states that he has had quite a bit of stress with his work and has not been maintaining a regular exercise program as he once did prior to his thyroid surgery." (AR 1049.) Dr. Insel's letter explains the need for Plaintiff to take Synthoid, a thyroid replacement medication, but no signs of recurrent disease. (AR 544.)

In October 1995, Dr. Wool, Plaintiff's treating physician, filled in a form stating that Plaintiff was disabled due to multiple problems derived from thyroid cancer. (AR 1369.) Dr. Wool's opinion in October 1995 was "severe chronic fatigue" associated with cancer-related treatments. (AR 1196 - 1197, 1369.) He opined that Plaintiff could work no more than forty hours a week or five days a week; lifting over ten pounds was the only physical restriction noted. Dr. Wool submitted two additional letters, in December 1996 and July 1997, reiterating his opinion that Plaintiff was totally disabled due to multiple problems. (AR 345, 634-35.)

Dr. Wool's conclusion that Plaintiff was totally disabled is not supported by Dr. Wool's records, other medical records, personnel records, and Plaintiff's own admissions. Plaintiff had a longtime, personal relationship with Dr. Wool which undoubtedly precipitated his ultimate conclusion.(AR 318, 333.)

Dr. Guevera's opinion in October 1995 was that the Plaintiff was "incapacitated and disabled due to his current urological conditions. . . his cancerous condition compromise[d] his immunological status and this result[ed] in

recurrent infections of the urinary tract. . . His prognosis [was] poor." (AR 829, 1385, 1364.) Dr. Guevera's December 1996 letter also reiterates his opinion that Plaintiff may no longer work as a mercantile purchaser. (AR 632.)

Dr. Guevera's own medical records and the Plaintiff's statements again do not support the ultimate conclusion that Plaintiff was totally disabled from his urological condition. The urology medical records are part of the file. (AR 1075 - 1118.) The records show flare-ups but generally no ongoing debilitating problem. Plaintiff's "chronic persistent prostatitis" was a condition that predated his thyroid cancer (February 2, 1993) and was well treated and controlled with medication. (AR 1094.)

Plaintiff was diagnosed with lymphedema in June 1995. Lymphedema alone or in combination did not render Plaintiff totally unable to work or travel. From June 1995: "Secondary lymphoma. . . spontaneously reversible. . . minimal severity." (AR 1003.) Pere Summers of the Lymphedema Treatment Center, wrote in June 1996,"Mr. Cooper is an excellent candidate for acquiring skills in self management of the lymphedema condition." (AR 1006.) A February 1997 letter from Mr. Summers states Plaintiff was experiencing an "increase in lyphodema." (AR 540.) A May 1997 letter from Mr. Summers states that Plaintiff may not participate in extensive physical activity and is no longer able to travel extensively. (AR 576.) Plaintiff's travel schedule during this time contradicts Mr. Summers' conclusion.

Plaintiff engaged in a certain amount of personal travel during this time frame: in February 22, 1996, he was just in

from Houston (AR 276); in February 1997, a trip to San Diego (AR 264); in March 1997, a trip back east to look for colleges (AR 261); a trip to Los Angeles in May 1997 (AR 258); and, in May 1997, a trip to Las Vegas for five days. (AR 257.) Defendant obtained airline travel records for Plaintiff in 1995-1997. (AR 340.) These coupled with the notes from Dr. Fox from 1993 through 1997 reveal that Plaintiff indeed resumed traveling for work and pleasure.

Defendant obtained statements from former Capin employees about Plaintiff. These statements confirm that Plaintiff did work during 1993 through 1995. (AR 319, 335, 692-699, 729.) Human resources' personnel records from 1993 through 1995 also confirm this. (AR 706-711, 714-716, 825, 904-905.) [9] Plaintiff himself claimed he was able to work six days a week, eight hours a day. [10] (AR 1368, 1203.)

The conclusion contained in Jim Miranda's letter that all job reductions and salary loss was directly related to Plaintiff's health is not supported by the record. (AR 651, 731-732.) Mr. Miranda authored a letter listing Plaintiff's salary and job responsibility reductions from 1993 -1995. (AR 1386.) In September 1993, Plaintiff was demoted as ad director. In August 1994, Plaintiff was relieved from his position as merchandise manager. Again, in January 1995, Plaintiff received a lower salary and fewer responsibilities.

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[9] The Court disregarded the unsigned letter marked "DRAFT" with Mr. Capin's name on the bottom. (AR 1359.)

[10] Mr. Stuchen stated that "the duties of a buyer never required anyone to work 70 to 80 hours a week." (AR 336.)

His salary in 1992 was $10,455 per month and reduced to $5000 per month by April 1995. (AR 834.) Plaintiff was an owner and, as such, received his full salary even though he was not working every day. (AR 441, 449, 1192.) During this time, the family business was suffering from financial losses. The company brought in a consulting company, GARR Consulting Group, to audit the business. (AR 806.) The GARR group audited the company for about nine months before issuing its recommendation. (AR 807, 944.) In August 1994, GARR rated Plaintiff the lowest in his department, as a 2-3 out of 10, and "not a team player, inexperienced, lacks leadership skills." (AR 816.) A plan for reorganization was set to go into effect in September 1994. (AR 810, 946.) Ultimately, the decision was made in April 1995 to cut their losses and sell the business. When the family business dissolved in November 1995, Plaintiff's job was described as a buyer. (AR 785.)

The Court finds that Plaintiff's loss of salary and reduction in responsibilities was primarily the result of the state of the family business rather than his medical condition, overall. The Court did not credit conclusions that loss of income and position were solely attributed to Plaintiff's health due to contradictory evidence in the record.

Plaintiff was offered but did not accept employment with the acquisition company. (AR 785-787.) Plaintiff was offered employment with the new company as a cashier/stocker (store associate) for $5000 per month for three months, but refused employment with the new non-family owned company. (AR 1120-1123.) The Court's conclusion is

that Plaintiff's decision not to accept employment was not based on the existence of a disabling impairment.

Finally, the Court did not find Plaintiff's claim, that his medical conditions rendered him totally unable to work as a merchandise buyer, credible. To reach this conclusion, the Court relied on Plaintiff's own statements to Dr. Fox, his activities (AR 332-335, 819-822), his medical records, and the statements of his co-workers. By June 1993, Plaintiff was working 50% to 60%. (AR 1203.) From November 1995, Plaintiff wrote, "Drs. have said I can work but when I become fatigued I must go home." (AR 700.) During the time he was not working, he was also not traveling. (AR 1203.) When he went back to work, he resumed traveling and was working from about 9:00 to 5:00 daily. (AR 707, 1204.) During a recorded statement taken by Defendant, on July 1, 1997, Plaintiff made statements which indicate that he was not totally disabled. (AR 430450.) He stated that he was basically working in the same capacity from 1993 through 1995, but according to a modified schedule. (AR 449.) He continued to receive full salary even though he was not there and he generally reassumed responsibilities when he came back. (AR 449.) The Court concludes that Plaintiff's decision not to work for a non-family owned business was a choice, not a necessity.

CONCLUSIONS OF LAW [11]

The parties do not argue and the Court does not find that the policy terms are ambiguous and incapable of interpretation according to ordinary understanding. In addition, the parties do not dispute that travel was a substantial and material part of Plaintiff's occupation as a mercantile buyer. Finally, the parties are not quibbling over the legitimacy of Plaintiff's health concerns.

Plaintiff would like this Court to rule that, because he could no longer travel as frequently, energetically, and comfortably as he did prior to his thyroidectomy (in combination with other health problems), he was rendered totally unable to work in his previous occupation as a mercantile buyer. To that end, Plaintiff relies on cases, outside of the Ninth Circuit, whose approach in similar cases is to examine the nature of the substantial and material duties that the claimant actually performed before his injury or sickness and to inquire whether after injury or sickness he can continue to perform them "'in the usual and customary way.'" *Blasbalg v. Massachusetts Cas. Ins. Co.*, 962 F. Supp. 362, 368 (E.D.N.Y.1997) (citation omitted).

Plaintiff relies heavily on *McFarland v. General Am. Life Ins. Co.*, 149 F.3d 583 (7th Cir.1998) (construing an identical total disability provision). In *McFarland*, the claimant was unable to perform the substantial and material duties of his regular occupation in the customary manner, and

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[11] In this section, the Court makes additional findings of fact along with its conclusions of law.

was therefore entitled to total disability coverage, "whenever there is a substantial change in the responsibilities, terms or conditions of [his] occupation." *Id.* at 588. The Seventh Circuit opined that a "qualitative performance reduction" can give rise to "total disability" within the meaning of certain policies. *Id.* A qualitative reduction has occurred if the claimant is "no longer able to perform an essential duty of his regular occupation, resulting in the loss of his position" or precluding him from continuing in his pre-injury employment. *Id.* at 587-88. The court held that the insured would be totally disabled within the meaning of the policy and entitled to benefits if there was a substantial change in the responsibilities, terms or conditions of his occupation. Ultimately, the court vacated the judgment of the district court and remanded for a clear determination on whether the disruption in the insured's occupational activities constituted an inability to function as an owner and operator of the corporation as he functioned prior to his injuries.

Plaintiff argues that his policy is an occupational-based policy and "occupational disability policies are designed to indemnify against loss of capacity to work, not against loss of income. . ." *Blasbalg*, 962 F. Supp. at 368; *see also* 44 Am. Jur. 2d Insurance § 1475 (1982); 10 Couch on Ins. § 147:2 (3d ed.). In *Blasbalg*, Mr. Blasbalg was a computer programmer whose duties involved an extensive use of his eyes. He began to suffer from eye strain and headaches, resulting in a condition that left him with painful, blurred vision in his right eye, then his left eye. Without the use of his eyes, Mr. Blasbalg could no longer work as a computer programmer. The reduction in the qualitative level of his work was never an issue.

Plaintiff also points to *Rahman v. Paul Revere Life Ins. Co.*, 684 F.Supp. 192 (N.D.Ill. 1988). *Rahman* involves an emergency cardiologist whose policy finds an insured disabled if he is unable to perform the substantial and material duties of his regular occupation in the usual and customary manner. The insured argued that after an accident he no longer could work as an emergency cardiologist. The court ruled on summary judgment that there was no question of material fact that insured was disabled within the terms of the policy. Plaintiff suffered loss of motion in his foot and leg such that he was unable to run to patients in cardiac arrest and running or quick movement was established as a substantial and material duty of his regular occupation as an emergency cardiologist. He totally lost the physical ability, running, to perform a duty required in his profession and he could not longer work as an emergency room cardiologist.

In turn, Defendant relies primarily on *Kaufman v. Provident Life and Cas. Ins. Co.*, 828 F. Supp. 275 (D.N.J. 1992)(construing identical policy language), *aff'd*, 993 F.2d 877 (3rd Cir. 1993) and *Ames v. Provident Life and Acc. Ins. Co.*, 942 F. Supp. 551 (S.D.Fla. 1994), *aff'd*, 86 F.3d 1168 (11th Cir. 1996). In Ames, a jury found that an orthopedic surgeon, rendered unable to perform surgery due to rheumatoid arthritis, continued to work part-time and was not totally disabled. The court in *Ames* denied a motion notwithstanding the verdict, because there was evidence that an orthopaedic surgeon could, without performing surgeries, still perform many of the substantial and material duties of his profession. *Id.* at 557. The court declined to find that the "great weight of the evidence" contradicted the jury's verdict. *Id.* In *Kaufman*, the court granted summary judgment in

Defendant's favor, finding that an optometrist was rendered only partially unable to continue his work due to treatment for thyroid cancer and lymphoma. Mr. Kaufman owned his own business and traveled in conjunction with his management duties, as well as saw patients. While undergoing follow-up treatment, Mr. Kaufman continued to work, run his business and travel. His physician opined that treatments for cancer rendered Mr. Kaufman totally disabled. Plaintiff argued that *Kaufman* is not applicable because Plaintiff underwent surgery for a total thyroidectomy rather than a partial. Here, as in *Kaufman*, "Provident denied the insured's claim for total disability benefits because he was still working and performing the substantial and material duties of his occupation on a part-time basis." (Defendant's Bench Trial Memorandum at 10.) "It is undisputed that in March 1991Kaufman reduced the number of hours he worked; however, he continued to run his business as a regular basis and continued to examine eyes as an optometrist." 828 F. Supp. at 286. His loss of income was attributable to independent issues affecting his corporation. Finally, Mr. Kaufman's decision to leave the practice of optometry was not due to an inability to practice, rather a desire to obtain total disability benefits. 828 F. Supp. 286-87.

Defendant also directed the Court's attention to various treatises in this area. The Court found those treatises most useful that explored the definition of "totally disabled" and the specific policy language in this case. The Court agrees with Plaintiff that this is a general occupational disability policy. 10

Couch on Ins. § 146:3 (3d ed.). [12] "To assess total disability the court is required to review all evidence that impacts the insured's overall activities. Such evidence consists of testimony and documentation pertaining to the medical condition, daily activities, and overall well being of the insured. This can consist of both lay and expert interpretation." 10 Couch on Ins. § 147:2 (3d ed.).

> Provisions in a disability policy requiring the insured be unable to perform every duty pertaining to his or her occupation must be given a liberal construction. For example, clauses which relate to the occupation to be considered in determining whether the insured is entitled to benefits will not be literally construed or applied where to do so, would make recovery of benefits unreasonably impossible in all or practically all cases. Thus, the duties of insured's occupation must be viewed as a whole and not separately or in piecemeal.

10 Couch on Ins. § 147:106 (3d ed.). "[U]nder the 'substantial performance' test, even though insured is able to perform some parts of his or her work, a case of total disability is presented where the insured is incapacitated from performing any substantial part of his or her ordinary duties." 10 Couch on Ins. §147:107 (3d ed.). "In cases involving persons engaged in retail merchandising, the courts have

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[12] Plaintiff's occupation as a mercantile buyer is well described in the record. (AR 1381, 832, 649-50.)

explained the concept of total disability by saying that the mere ability to engage intermittently in some sort of work which the insured had been capable of performing in the past does not negative total disability." 44 Am. Jur. 2d Insurance § 1476 (1982).

> [T]he general rule is that the mere fact that an insured employee can do or has done, for a limited period, or at irregular intervals, some work, either in his usual occupation or in some other occupation, does not in itself preclude the existence of a total and permanent disability within the meaning of a disability clause in a group policy, as long as he is not capable of performing work with reasonable regularity over an extended period of time.

44 Am. Jur. 2d Insurance § 1856 (1982).

Looking to the law in the Ninth Circuit, Defendant argues that *Deegan v. Continental Casualty Co.*, 167 F.3d 502 (9th Cir. 1999) and *Saffle v. Sierra Pacific Power Co.*, 85 F.3d 455 (9th Cir. 1996) apply. *Saffle* involved an interpretation of an ambiguously worded two-tier disability policy. The definition of total disability was narrower than the one here because of the wording of the policy: "complete inability of claimant to perform each and every duty of his regular occupation." *Saffle*, 85 F.3d at 457. Saffle worked in a clerical position and experienced pain and other complications as the basis for her total disability claim. The court found that "Saffle's preferred construction would effectively convert benefits for total disability into benefits for

partial disability." *Id.* at 459. The court determined not to interpret words as to "arbitrarily substitute quantity for quality." *Id.* Finally, the court would not allow either party to rewrite the policy terms, by way of interpretation, to suit their respective position. *Deegan* involved a policy containing both a total and a partial disability clause. The court there, as here, determined not to construe the policy to cover total disability when the facts did not support it. 167 F.3d at 504 -507. The meaning of "totally disabled" in an ERISA policy is essentially a factual question subject to a clearly erroneous standard of review. *Id.* at 508.

Plaintiff relies on *McClure v. Life Ins. Co. of North America,* 84 F.3d 1129 (9th Cir. 1996). *McClure* involved a policy that provided for total disability if the claimant (in this case, a fire-fighter) was completely unable during the first year to perform "every" duty of his occupation. 84 F.3d at 1133. The court interpreted this ambiguous phrase as if an employee was unable to perform one of the essential duties of his position. *Id.* at 1134. "His physical limitations prevent him from working with reasonable continuity in his customary occupation or in any other occupations in which he might reasonably be expected to engage." *Id.* The policy in *McClure* was construed in favor of the insured to mean total disability existed if the insured was unable to perform the essential duties of his or her profession. The firefighter in *McClure* was rendered unable to perform the physical requirements of his occupation. "He was unable to perform the physical duties required by his job, however, and performed light duties, not actual fire fighting. In October 1989, he was forced to stop working, as no light duty was available." *Id.* at 1132. It is not hard to understand that a firefighter who can no longer

physically do what is necessary cannot work as a firefighter and is totally disabled from working in his occupation. He was totally precluded from participating in the physical aspects of his profession and his profession consisted primarily of physical requirements. In *McClure*, there was no degree of loss of ability, i.e., a qualitative reduction, there was a total loss of ability to perform the requisite physical acts.

In deciding this case, this Court has also reviewed *Ellis v. Egghead Software Short-Term and Long-Term Disability Plans*, 64 F. Supp. 2d 986 (E.D. Wash. 1999). The court found that Ellis was disabled from working in his regular occupation, a retail project manager for Egghead Software, by fatigue and other symptoms from fibromylagia. "The record establishes that Ellis's job was extremely demanding both physically and mentally. Ellis traveled frequently to the sites of new Egghead stores where he was required to work 14-hour days for 4 to 5 days in a row in order to meet tight construction deadlines." *Id.* at 993. He was required to be alert and physically fit, but fibromylagia interfered with his efforts. Unlike in *Egghead*, here Plaintiff himself admitted that depression associated with the failure of the family business coupled with the negative report by GARR on his performance abilities played a significant role in his decision to find an alternative profession, rather than inability to perform his job due to health concerns.

In *Dym v. Provident Life and Acc. Ins. Co.*, 19 F. Supp. 2d 1147 (S.D. Cal. 1998), Provident makes a similar argument as it did in this case with regard to the comparison of the terms of the total disability clause and the residual

disability clause. Again, there is no residual disability clause in the policy at issue in this case. Plaintiff's policy covers total disability, but not partial disability. To interpret otherwise would result in rewriting the contract between the parties.

This Court may also examine state law if it is consistent with the goals and objectives of ERISA. *Deegan*, 167 F.3d at 506. In *Radkowsky v. Provident Life & Acc. Ins. Co.*, 196 Ariz. 110 (Ariz. App. 1999), the court found that "to recover from an occupational disability policy, the disability need 'be such as to render (the insured) unable to perform the substantial and material acts of his own occupation in the usual or customary way.'" 196 Ariz. at 112 (citing to *Nystrom v. Massachusetts Cas. Ins. Co.*, 148 Ariz. 208 (Ariz. App. 1986)). In *Radkowsky*, the insurance company prevailed because the physician had from the inception of his medical career limited his practice due to serious eye problems. He was successful in a group practice despite his eye problems but not in solo practice. Similarly, Plaintiff in the case at bar was presented with a situational change and this, more than anything else, influenced his decision not to continue working as a merchandise buyer. Plaintiff chose not to test whether he could be successful as a merchandise buyer in a non-family owned business.

The Ninth Circuit has not used the Plaintiff's language "qualitative performance reduction." Here, Plaintiff's attempt to portray his temporary part-time inability to work as a "qualitative reduction" in ability to perform certain tasks is an effort to avoid the distinction between total and partial disability. The Ninth Circuit does recognize a difference between partial and total disability. *Deegan*, 167 F.3d at 509.

Here, Plaintiff reduced the number of hours and days he worked over a period of two years, but continued to perform all of the substantial and material duties of his profession, including travel.

After *a de novo* review of the administrative record in conjunction with the law in the Ninth Circuit, the Court finds that the greater weight of the evidence supports Defendant's decision not to award total disability benefits. [13] The medical records do not support Dr. Wool's or Dr. Guevera's conclusions that Plaintiff was totally disabled. Those medical records that contain notations concerning fatigue and inability to travel are all based on Plaintiff's subjective complaints. During the same time period, Dr. Fox's notes reflect that Plaintiff resumed his work responsibilities, as well as traveled for work and pleasure by June 1993. Plaintiff's admissions and his co-worker's statements corroborate this. Plaintiff was not rendered unable to travel, as the firefighter in *McClure* was rendered unable to perform the physical requirements of his occupation. The record reflects that Plaintiff's decision to apply for disability benefits was primarily motivated by the family business dissolution and Plaintiff's awn reflections on his life, rather than his health concerns. Indeed, Plaintiff's health concerns abated and appeared to be well-controlled through medication and self-treatment. There is evidence in the record to contradict Mr. Miranda's conclusion that all of the salary reductions and demotions experienced by Plaintiff were attributed to his health. Plaintiff was capable of

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[13] "The insured must establish the burden of proof by a greater weight of the evidence." 10 Couch on Ins. §147.29 (3d ed.).

performing his work with reasonable regularity over extended periods of time. Plaintiff's loss of job responsibilities and reduction in salary were a reflection of the uncertain state of the family business rather than Plaintiff's health. As an owner, Plaintiff's salary fluctuations reflected the state of the business and the transfer of his job responsibilities was associated with the reorganization.

Accordingly, common sense dictates a finding that Plaintiff was never totally disabled within the terms of the policy and not entitled to an award of benefits.

CONCLUSION

Final judgment is entered in Defendant's favor. Section 1132(g) (1) of 29 U.S.C. gives the Court discretion to award attorney fees to either party in an ERISA action. After consideration of the factors in *Hummell v. S. E. Rykoff & Co.*, 634 F.2d 446, 453 (9th Cir. 1980) [14] , the Court has determined to rule that each party is to bear their own attorney fees and costs.

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[14] The *Hummell* factors are: (1) the degree of opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of fees; (3) whether an award of fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Dated this 29th day of March, 2001.

/s/_____
JAMES C. CARRUTH
United States Magistrate Judge

APPENDIX D

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

No. CV-97-490-TUC-JC

[Filed August 28, 1998]

DAVID C. COOPER, a married man, Plaintiff,	)
v.	)
PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY, a Stock Corporation, Defendant.	)

ORDER

Pending before the Court are Defendant's April 8, 1998 Motion for Summary Judgment and Plaintiff's May 8, 1998 Cross-Motion for Partial Summary Judgment. Oral argument was heard on August 11, 1998. Based on the following, the Court will grant Defendant's motion and deny Plaintiff's cross-motion. Also pending before the Court are Plaintiff's Motion to Strike Defendant's Statement of Facts, Plaintiff's Motion to File Supplemental Statement of Facts Under Seal and Defendant's Motion to Strike Plaintiff's Supplemental Statement of Facts.

I. BACKGROUND

This action arises out of an insurance claim made by the Plaintiff, David C. Cooper, under a disability insurance policy issued by the Defendant, Provident Life and Accident Insurance Company (Provident). On August 1, 1997, Plaintiff filed a two-count complaint against Provident asserting (1) breach of contract, and (2) breach of duty of good faith and fair dealing. Plaintiff alleges that he has been "totally disabled" as defined by the terms of his insurance policy since at least November 1995. (Complaint, p. 3). On or about September 27, 1995, while employed by Capin Mercantile Corporation, Plaintiff submitted a claim for total disability benefits. In November 1995, Capin Mercantile went out of business. On or about December 16, 1996, Plaintiff resubmitted a claim for disability. (Id. at 2). Defendant has refused to pay any total disability benefits under its insurance contract. (Id. at 3). Mr. Cooper asserts that Provident breached the express provisions of the insurance contract and violated its duty of good faith and fair dealing when it failed to pay disability benefits due to him under the terms of the contract.

Defendant filed an answer on October 2, 1997. Defendant asserts that it has fully performed any and all contractual and other duties it has under the policy and at all relevant times it has acted in good faith and in a reasonable manner. As an affirmative defense, Defendant also asserts that Plaintiff's claims are preempted by ERISA. (Answer, p.4).

Defendant filed a Motion for Summary Judgment requesting that the Court grant summary judgment in its favor because Plaintiff's complaint is preempted by the provisions

of the Employee Retirement Income Security Act of 1974 ("ERISA"), as the insurance policy issued in Plaintiff's name by Provident was part of an "employee welfare benefit plan" as that term is defined in 29 U.S.C. § 1001 *et seq*. Plaintiff counters that (1) the insurance plan was not an employee welfare benefit plan, (2) if a group disability insurance plan existed, it is exempted from ERISA because it falls within the "safe harbor" regulation, and (3) at the time of the alleged improper conduct by Provident, any ERISA plan that might have existed was no longer in existence. Plaintiff also filed a Cross-Motion for Partial Summary Judgment requesting that the Court find that ERISA is not applicable and that the claims for benefits are governed by state law. (Answer, p.18). However, if the Court grants Defendant's Motion for Summary Judgment, Plaintiff requests an opportunity to amend his complaint to allege an ERISA claim.

II. DISCUSSION

A. Summary Judgment Standard

Summary judgment is appropriate only when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c).

The initial burden rests on the moving party to prove the absence of any genuine issue of material fact. Once satisfied, the burden shifts to the non-moving party to demonstrate through production of probative evidence that there remains an issue of fact to be tried. *Celotex Corp. v.*

Catrett, 477 U.S. 317, 323-24 (1986); *Gasaway v. Northwestern Mut. Life Ins.* Co., 26 F.3d 957, 959 (9th Cir. 1994). "[A]n adverse party may not rest upon the mere allegations or denials of the adverse party's pleading." Fed. R. Civ. P. 56(e) .

When judging the evidence at the summary judgment stage, a district court is required to view all inferences in the light most favorable to the non-moving party. *Musick v. Burke,* 913 F.2d 1390, I394 (9th Cir. 1990). The ultimate question is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 251-52 (1986). The mere existence of a scintilla of evidence supporting the non-movant's position will be insufficient; there must be evidence from which the jury could reasonably find for the non-movant. *Id.* at 252.

B. Merits of Summary Judgment Motions

"ERISA preempts all state law claims that 'relate to any employee benefit plan. . . '" *Crull v. GEM Ins. Co.*, 58 F.3d 1386, 1389 (9th Cir. 1995) (quoting 29 U.S.C. § 1144(a)). "The Supreme Court has held that ERISA preempts state common law tort and contract causes of action asserting improper processing of a claim for benefits under an insured employee benefit plan." *Bast v. Prudential Ins, Co. of America,* F.3, No. 97-35429, 1998 WL 462694, at *5 (9th Cir. Aug. 3, 1998); (citing *Pilot Life Ins, Co. v. Dedeaux,* 481 U.S. 41, 57 (1987)). Therefore, the Court first must determine whether Provident's disability insurance is an "employee welfare benefit plan." "The answer to that

question turns on whether uncontroverted evidence establishes that [Capin Mercantile's] role with relation to the insurance program is sufficient to render it an ERISA plan." *Zavora V. Paul Revere Life Ins. Co.*, 145 F.3d 1118, 1120 (9th Cir. 1998) . Because ERISA preemption is a federal defense, the burden is on the Defendant to prove the facts necessary to establish it. *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489, 492 n.4 (9th Cir. 1988), *cert. denied*, 492 U.S. 906 (1989).

"The existence of an ERISA plan is a question of fact, to be answered in light of all the surrounding facts and circumstances from the point of view of a reasonable person." *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d at 492 (citation omitted). "To determine whether an insurance plan is an ERISA plan, a district court should consider 29 U.S.C. § 1002(1), which defines an employee welfare benefit plan, and 29 C.F.R. § 2510.3-l(j), which clarifies the meaning of 'establishing and maintaining' such a plan." *The Meadows v. Employers Health Ins.*, 826 F. Supp. 1225, 1228 (D. Ariz. 1993) (citations omitted), *aff'd*, 47 F.3d 1006 (9th Cir. 1995).

An "employee welfare benefit plan" is defined as follows:

> any plan, fund, or program which... is... established or maintained by an employer... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment....

29 U.S.C. § 1002(1). The Ninth Circuit has stated that an "employee welfare benefit plan" exists if five requirements are met:

> (1) a "plan, fund or program" (2) established or maintained (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, unemployment or vacation benefits, apprenticeship or other training programs, day care centers, scholarship funds, prepaid legal services or severance benefits (5) to the participants or their beneficiaries.

Kanne v. Connecticut General Life Ins. Co., 867 F.2d at 491-92 (quoting *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc) . Requirements 3, 4 and 5 listed above are clearly met; however, the Court must determine whether Capin Mercantile "established or maintained" a "plan, fund or program."

A "plan, fund, or program" exists if, from the surrounding circumstances, "a reasonable person can ascertain the intended benefits, a class of beneficiaries, the source of financing, and procedures for receiving benefits." *Donovan v. Dillingham,* 688 F.2d at 1373; *see also Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1504 (9th Cir. 1985). "[T]he existence of a written instrument is not a prerequisite to ERISA coverage." *Scott v. Gulf Oil Corp.*, 754 F.2d at 1503 (citation omitted). Although no documents defining the terms of the plan have been produced, as Defendant asserts, the intended benefits are clearly disability insurance benefits, the class of

beneficiaries is the group of Capin Mercantile employees covered under the plan, the source of financing is Capin Mercantile's payment of premiums pursuant to the Salary Allotment Agreement, and the procedures for receiving benefits are included in the insurance policies issued in each employee's name. Hence, a plan/program existed, but the question remains whether Capin Mercantile's involvement with the insurance plan/program is sufficient to render it an ERISA plan.

The Ninth Circuit has stated that "[a]n employer. . . can establish an ERISA plan rather easily." *Credit Managers Ass'n of Southern California v. Kennesaw Life and Accident Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). In fact, the Ninth Circuit has held that "'[e]ven if an employer does no more than arrange for a "group-type insurance program," it can establish an ERISA plan, unless it is a mere advertiser who makes no contributions on behalf of its employees.'" *Cruel v. GEM Ins. Co.*, 58 F.3d at 1389 (quoting *Credit Managers Ass'n*, 809 F.2d at 625) (applying Department of Labor regulations that establish conditions under which an employer's purchase of group insurance on behalf of its employees does not establish an "employee welfare benefit plan" for purposes of ERISA, 29 C.F. R. § 2510.3-1(j)) .

To aid in the determination of whether an ERISA plan was established or maintained by an employer, "the Secretary of Labor has issued an interpretive regulation that creates for certain employer practices a 'safe harbor' from ERISA coverage." *Zavora v. Paul Revere Life Ins. Co.*, 145 F.3d at 1120. The safe harbor regulation provides:

> For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
>
> (1) No contributions are made by an employer or employer organization;
>
> (2) Participation [in] the program is completely voluntary for employees or members;
>
> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or checkoffs.

29 C.F.R. § 2510.3-1(j). If Capin Mercantile does not fall within the "safe harbor," i.e., it has failed to limit its activities to those specified in the safe harbor regulation, this is evidence of the establishment of an ERISA plan, but is not

conclusive. *Id.* at 1121 (citation omitted). "That evidence must be considered along with 'all the surrounding circumstances' to determine whether an ERISA plan exists." *Id.* (quoting *Credit Managers Ass'n*, 809 F.2d at 625) .

Only the first and third "safe harbor" criteria are at issue here. It is undisputed that, from 1989 to October 1995, Capin Mercantile paid the insurance premiums using its corporate checking account. However, the question remains whether the safe harbor criteria are met if the premiums paid by Plaintiff's former employer were treated as non-salary compensation and taxed as income to Plaintiff at the end of the year.

In *Crull*, the Ninth Circuit recognized that since "[a]n employer who pays a portion of an employee's premiums can be expected to recoup that cost by paying the employee an otherwise lower wage, . . . there is little economic difference (excepting tax consequences) between in-kind payments of health insurance and deductions from an employee's payroll." *Crull*, 58 F.3d at 1390. However, the Court went on to state that "[n]evertheless the [Department of Labor's] regulations and our precedents recognize an employer's payment of. . . the insurance premium as a significant factor for determining the existence of an ERISA plan." *Id.* Hence, it appears that the Ninth Circuit does not look to the economic implications (with respect to salary) or the tax consequences of the employer's premium payments. But instead, considers the actual payment of premiums by the employer to be a determining factor.

In this case, even though the evidence shows that, at least in 1994, the premiums paid by the employer were treated

as non-salary compensation to Plaintiff on his W-2 at the end of the year, the fact remains that Capin Mercantile paid the premiums from 1989 through October 1995. Plaintiff argues that his funds were used to pay the premium because his employer made a year-end decision to declare the payments made on Plaintiff's behalf as non-salary compensation, and thus, the employer's only involvement was a payroll deduction. The Court finds this argument is unavailing. As the Ninth Circuit stated, the fact that Capin Mercantile paid the premiums is a significant factor for determining the existence of an ERISA plan. There is no evidence that the premiums for Plaintiff's policy were paid through a payroll deduction program.

In addition to the payment of premiums, the evidence shows that Capin Mercantile engaged in a number of other activities with respect to the insurance plan, which indicate that Capin Mercantile was more than a mere advertiser. "[A]s long as the employer merely advises employees of the availability of group insurance, accepts payroll deductions, passes them on to the insurer, and performs other ministerial tasks that assist the insurer in publicizing the program, it will not be deemed to have endorsed the program under section 2510.3-1(j) (3) ." *Johnson v. Watts Regulator Co.*, 63 F.3d 1129, 1134 (1st Cir. 1995) (citing *Kanne*, 867 F.2d at 492; *du Mortier v. Massachusetts General Life Ins. Co.*, 805 F. Supp. 816, 821 (C.D. Cal. 1992)). Here, the Court finds that Capin Mercantile's level of involvement with the insurance plan is inconsistent with the third prong of 29 C.F.R. § 2510.3-1(j).

As Mr. Thompson, a team leader in Provident's Underwriting Department, stated in his affidavit, pursuant to the Salary Allotment Agreement, Capin Mercantile was

ultimately responsible for the payment of the premiums. (Thompson Aff., ¶ 6). Capin Mercantile agreed to pay in full the required premiums rather than make salary deductions for required premiums. (Def.'s Supp. SOF, Ex. A). In fact, at one point, Provident requested that Capin Mercantile pay the premium due in order to keep the plan in force. (Def.'s SOF, Ex. H). In addition, it is undisputed that Capin Mercantile was billed for all the premiums, paid the premiums and received any refunds of overpayment.

Mr. Thompson also averred that Capin Mercantile had authority to and actually decided when to terminate the Plan. (Thompson Aff., ¶¶ 18 & 19). As stated above, Capin Mercantile was ultimately responsible for the payment of premiums, and thus, could let the plan lapse by failing to pay the required premiums. In addition, the evidence shows that Capin Mercantile discontinued policies for certain employees. (Def.'s SOF, Ex. I). The evidence also shows that Mr. Cooper's policy was cancelled effective November 1, 1995 "[d]ue to entire group being cancelled," which was done at the direction of Capin Mercantile's Chief Financial Officer. (Def.'s SOF, Ex. J) .

In addition, Mr. Thompson attested that it is "most likely" that Capin Mercantile selected the specific insurance product to be made available to its employees, the benefit period and the elimination period since the underwriting file indicated that all of Capin's employees had the same insurance product (form #335), the same benefit period (to age 65), and the same elimination period (365 days) and the policies had the same effective date (May 1, 1989). (Thompson Aff., ¶¶ 13 & 14). Based on the circumstances and Mr. Thompson's uncontroverted sworn statement, the Court finds that Capin

Mercantile selected the plan for its employees because all the employees had the same insurance product, benefit period, elimination period and effective date. Also, the evidence indicates that Capin Mercantile chose Provident over other insurance companies to provide disability insurance to its employees. (Thompson Aff. ¶ 18; Def.'s Supp. SOF, Ex. F).

Moreover, Capin Mercantile's name (Capin Mercantile Corporation Risk Group #72325) identified the disability insurance plan and Capin Mercantile gave Provident a binding check during the application process. (Thompson Aff., ¶ 18; Def.'s SOF, Exs. B & D; Def.'s Supp. SOF, Ex.F). Standing alone, these facts might not support a finding that Capin Mercantile established or maintained an employee welfare benefit plan. However, when considered with all the evidence, these facts lend support to a finding that Capin Mercantile established an employee welfare benefit plan.

Mr. Thompson also attested that the plan Capin Mercantile selected included a Summary Plan Description Form 1814 ("SPD"), which would be generated by Provident's automated form system and sent to Capin Mercantile in accordance with Provident's standard operating procedure. The SPD allegedly informed Plaintiff that his policy was part of an employee welfare benefit plan governed by ERISA. (Thompson Aff., ¶¶ 16 & 17). However, Plaintiff stated that he never received a Summary Plan Description. (Cooper Aff., ¶6). Nevertheless, the failure to comply with administrative and reporting requirements detailed under ERISA, does not exempt employers from ERISA coverage. *See Scott v. Gulf Oil Corp.*, 754 F.2d at 1503. Also, "the determination of when a plan becomes subject to ERISA... does not hinge on the sending of an SPD by the plan

administrator." *Taylor v. Carter*, 948 F. Supp. 1290, 1295 (W.D. Tex 1996). Hence, even though Mr. Cooper averred that he never received the SPD, the fact remains that Provident's Issue Summary for Plaintiff directed that the SPD be included. (Def.'s SOF, Ex. D)Hence, the evidence establishes that Provident believed it was issuing Plaintiff's disability policy as part of an ERISA plan.

Based on the uncontroverted facts and surrounding circumstances the Court finds that Capin Mercantile's activities transcend the safe harbor boundaries. Therefore, the plan in question is an ERISA plan.

Finally, Plaintiff argues that at the time of the alleged improper conduct by Provident, Capin Mercantile was no longer in existence, and thus, any plan that might have existed and might have been subject to ERISA regulation was no longer in existence.

Defendant relying on *Qualls v. Blue Cross of Calif., Inc.*, 22 F.3d 839 (9th Cir. 1994) and a number of other Ninth Circuit cases, contends that the Ninth Circuit has repeatedly held that once an employer establishes an ERISA plan, any change in the plan or policies within the plan, including the method of premium payments, does not change the fundamental nature of the plan or policies within the plan. (Def.'s Reply, pp.7-9) . In *Qualls*, the plaintiff, like Mr. Cooper, elected to continue coverage of his insurance policy after he stopped working for his employer. *Id.* at 842 n.1. In that case, the Ninth Circuit rejected the plaintiff's argument that his policy was not covered by ERISA:

> - Mr. Qualls also argues, in his reply brief, that the policy was not covered by ERISA because once he was no longer employed at Saddleback his continued coverage was based on a simple private policy, unrelated to employment. He bases this argument on the fact that Blue Cross was not obligated by COBRA to allow him to continue providing him with coverage under the policy. *See* 29 U.S.C. § 1162 (continuing coverage requirement limited to plans with more than 20 members). This argument fails to take note of the fact that Mr. Qualls's continuing eligibility was based solely on his previous employment at Saddleback. If the policy was governed by ERISA when he was at Saddleback, it continued to be governed by ERISA once he left. *See Tingey v. Pixley-Richards West,* 953 F.2d 1124, 1132-1133 (9th Cir. 1992) (converted insurance policies continued to be governed by ERISA).

Quails, 22 F.3d at 843 n.4; *see also Peterson v. American Life & Health Ins. Co.*, 48 F.3d 404, 408 (9th Cir.) (stating that policies derived from ERISA plans continue to be governed by ERISA even after conversion from a group policy to individual policy after leaving employment), *cert. denied*, 516 U.S. 942 (1995); *Greany v. Western Farm Bureau Life Ins. Co.*, 973 F.2d 812, 817 (9th Cir. 1992) (because plaintiffs would not be eligible for conversion policy without first belonging to the class of beneficiaries covered by the ERISA group plan, individual conversion benefits are part of the ERISA plan and are thus governed by ERISA); *Tingey v. Pixley-Richards West, Inc.*, 953 F.2d 1124, 1132-33 (9th

Cir. 1992) (converted insurance policies continue to be governed by ERISA).

According to Mr. Thompson, after Capin Mercantile went out of business, Plaintiff continued to be eligible for the same disability insurance coverage at the same discounted premium rates solely because of his previous employment at Capin Mercantile and his prior status as a covered employee belonging to the class of beneficiaries covered by the plan. (Thompson Aff., ¶¶ 22-24). In view of the Ninth Circuit precedent, the Court concludes that since the policy was governed by ERISA when Plaintiff was employed at Capin Mercantile, it continued to be governed by ERISA after Plaintiff ceased working for Capin Mercantile. The fact that Plaintiff left his employment at Capin Mercantile because the corporation went out of business does not change this result.

C. Other Motions

Plaintiff moves to strike Defendant's Statement of Facts as not supported by admissible evidence as required by rule 56(e) . Pursuant to Fed. R. Civ. P. 56(e), "material presented on summary judgment must be admissible under the rules of evidence." *In re Sunset Bay Associates*, 944 F.2d 1503, 1514 (9th Cir. 1991). Hearsay evidence may be considered in support of a motion for summary judgment if it falls within one of the exceptions to the hearsay rule. *See, e.g., Beyene v. Coleman Sec. Services, Inc.*, 854 F.2d 1179, 1183 n.4 (9th Cir. 1988)(business records exception).

With regard to the documents generated by Provident, the Court finds that Mr. Thompson's affidavit satisfies any evidentiary deficiencies. Mr. Thompson affirmed that

> all of those documents that were generated by Provident were generated at or near the time by, or from information transmitted by, a person with knowledge, and were and are kept in the normal course of Provident's regularly conducted business activities, and it was and is the regular practice of Provident to generate and keep such documentation when an employer is selecting and establishing a disability insurance plan for the welfare and benefit of its employees.

(Thompson Aff., ¶ 3). Hence, these documents are admissible as business records.

With regard to the documents generated by Capin Mercantile, Mr. Thompson averred that Provident received and maintained the documents in its business records in the normal course of its regularly conducted business activities and relied on the information contained in each document as evidenced by certain exhibits. (Id., ¶ 4). Therefore, the Court finds that the documents generated by Capin Mercantile are trustworthy as Provident received and maintained them in the normal course of business, and Provident, which had a substantial interest in their accuracy, relied on those documents. *See United States v. Childs,* 5 F.3d 1328, 1334 (9th Cir. 1993), *cert. denied*, 511 U.S. 1011 (1994) . Hence, the documents are admissible as business records, and thus, Plaintiff's Motion to Strike is denied.

On August 6, 1998, Plaintiff filed a Motion to File Supplemental Statement of Facts Under Seal. Defendant requests that the Court strike Plaintiff's Supplemental

Statement of Facts and deny Plaintiff's Motion to File Pleading Under Seal because (1) Plaintiff's motion constitutes litigious gamesmanship, (2) the pleading proves his complaint is preempted by ERISA, and (3) the pleading is irrelevant as a matter of law to the ERISA preemption issue. Even though the Court does not condone the Plaintiff's late filing, as indicated at oral argument, the Court will grant Plaintiff's Motion to File Pleading Under Seal and will deny Defendant's Motion to Strike.

III. CONCLUSION

The Court finds that Capin Mercantile's actions are sufficient to show the establishment of an "employee welfare benefit plan" as defined by ERISA, and that Plaintiff's policy continued to be governed by ERISA even after he stopped working for Capin Mercantile. Therefore, Plaintiff's complaint, which raises only state common law claims, is preempted by ERISA.

Accordingly, IT IS **ORDERED** that:

(1) Defendant's Motion for Summary Judgment (Doc. #35) is **GRANTED**;

(2) Plaintiff's Cross-Motion for Partial Summary Judgment (Doc. #50-1) is **DENIED**;

(3) Plaintiff's Motion to Strike Defendant's Statement of Facts (Doc. #49) is **DENIED**;

(4) Plaintiff's Motion to File Pleading Under Seal (Doc. #64) is **GRANTED;**

(5) Defendant's Motion to Strike Plaintiff's Supplemental Statement of Facts (Doc. #65) is DENIED; and

(6) Plaintiff's complaint is **DISMISSED WITHOUT PREJUDICE** to refiling an amended complaint alleging an ERISA claim within thirty (30) days of the date of the filing of this ORDER.

DATED this 28th day of August, 1998.

/s/_____
JAMES C. CARRUTH
United States Magistrate Judge

Supreme Court, U.S.
FILED
OCT 14 2002
OFFICE OF THE CLERK

No. 02-462

IN THE

Supreme Court of the United States

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Petitioner,

v.

DAVID C. COOPER,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION

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Introduction

In its Petition for Certiorari, Petitioner suggests that this Court should grant discretionary review and overturn an unpublished memorandum decision of the Ninth Circuit Court of Appeals. Petitioner suggests that review is appropriate because the Ninth Circuit's decision creates a conflict of law amongst the circuit courts and is inconsistent with the statutory language of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, *et seq.*[1] As is set forth more fully below, Petitioner's arguments are without merit, and there is no good reason for this Court to exercise its discretionary review of the memorandum decision of the Ninth Circuit Court of Appeals. Accordingly, the Petition for Writ of Certiorari should be denied.

Relevant Material Facts

As Petitioner correctly points out, the case presents the issue of whether ERISA continues to govern a claim for wrongful denial of disability insurance benefits even if there is no employee benefit plan at the time the benefit determination is made. The Ninth Circuit ruled that state law claims for wrongful denial of insurance benefits are not preempted by ERISA once the relevant employer sponsored plan has been terminated. In reaching this decision, the circuit court relied on the following facts.

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1. Petitioner also argues that the lower court's decision is inconsistent with prior decisions of the Ninth Circuit Court of Appeals and is contrary to the factual findings made by the district court. Neither of these issues is of the type that merit review by this Court. *See* Rule 10(a), United States Supreme Court Rules of Practice.

Respondent, David Cooper, was the named insured under an individual disability income policy issued by Provident. (App. 9a). The district court concluded that the individual disability insurance policy was part of an employer sponsored plan. (App. 9a).[2] In November of 1995, Mr. Cooper's employer terminated the ERISA plan. (App. 8a). After his employer terminated its involvement in the benefit plan, Mr. Cooper continued his disability insurance coverage by making the premium payments himself. (App. 43a).

In September of 1995, Mr. Cooper filed a claim for benefits under his disability insurance policy. (App. 10a). In December of 1996, Mr. Cooper filed a second claim for benefits under the disability coverage. (App. 10a). Provident treated Mr. Cooper's second claim for benefits as a request to reopen his initial claim. (App. 10a). In June of 1997 (over a year and a half after the employer terminated the plan), Provident responded to Mr. Cooper's claim. (App. 10a). At that time, the company refused to pay Mr. Cooper's claim for disability benefits. (App. 10a).

The Ninth Circuit's Memorandum Decision Has No Precedential Effect; Therefore It Cannot Create A Conflict Of Authority Amongst The Circuit Courts

In its Petition for Writ of Certiorari, Petitioner argues that the Ninth Circuit's decision creates an irreconcilable conflict with rulings from other circuit courts. Noticeably absent from the Petition, however, is any reference to the fact that the Ninth Circuit's decision was designated as a memorandum disposition. (App. 3a). Under the Rules of the

---

2. The Ninth Circuit assumed without deciding that Mr. Cooper's insurance policy was part of an ERISA plan. (App. 4a).

Ninth Circuit, memorandum decisions of the court are not binding precedent and may not be cited except as relevant under the doctrines of law of the case, res judicata, and collateral estoppel. *See* Rule 36-3, Ninth Circuit Rules. Insofar as the Ninth Circuit's decision is not binding precedent, by definition, it cannot create a conflict with any ruling by any other court.

The Ninth Circuit's Memorandum Decision Is Consistent With Prior Rulings Of This Court

The issue presented by the Petition is whether ERISA preempts state law claims which arise *after* an employer sponsored plan has been terminated. While this Court has never addressed this specific issue, the Ninth Circuit's decision in the present case is consistent with the rationale of this Court's decisions interpreting the preemption provision of ERISA.

ERISA's preemption provision is set forth in 29 U.S.C. § 1144(a). The statute provides:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supercede any and all state laws insofar as they may now or hereafter relate to any Employee Benefit Plan described in § 1003(a) of this title. . . .

In *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1 (1987), the Court explained the purpose underlying the preemption provision of ERISA. In the *Fort Halifax* case, the Court concluded that state law claims for severance pay were not preempted by ERISA. One of the bases of the Court's decision

in *Fort Halifax* was that preemption of the state law at issue would not have furthered the purpose underlying the preemption provision of ERISA. *Id.* at 8. The Court in *Fort Halifax* explained that the problem that ERISA's preemption provision was intended to address was the need to "eliminate the threat of conflicting and inconsistent state and local regulation." *Id.* at 9 quoting 120 Cong. Rec. 29197 (1974). Thus, the Court concluded that preemption would only be appropriate if the state law interfered with an employer's ongoing administration of an employee benefit plan.

> The purposes of ERISA's preemption provision make clear that the Maine statute in no way raises the types of concerns that prompted preemption. Congress intended preemption to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations. This concern only arises, however, with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation. It is for this reason that Congress preempted state laws relating to *plans*, rather than simply to *benefits*. Only a plan embodies a set of administrative practices vulnerable to the burden that would be imposed by a patchwork scheme of regulation.

Id. at 11-12 (emphasis in the original).

In addressing whether ERISA was applicable to Mr. Cooper's state law claims, the Ninth Circuit reasoned that a state law claim does not "relate to" an employee benefit plan if the state law claim arises after the employer has

terminated its ongoing involvement in the plan. The court stated:

> Accordingly, even if there had been an ERISA plan in existence when the company was still functioning, there was no ERISA plan after it ceased doing business and Cooper continued independently to make full payment of premiums. The case is therefore controlled by our decision in *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872, 874 (9th Cir. 2001).

(App. 4a).

In *Waks*, the Ninth Circuit addressed the issue of whether ERISA preempted a claim filed by a person who was insured under an individual health policy which had been converted from an ERISA governed group health plan. The Ninth Circuit in *Waks* held that such conversion coverages are not subject to ERISA preemption. *Waks*, 263 F.3d at 875. Central to the Ninth Circuit's decision in *Waks* was the rationale set forth by this Court in *Fort Halifax* that ERISA preemption is not applicable unless there is ongoing administrative involvement by the employer.

> We conclude that claims arising under a converted individual policy are not "related to" an ERISA plan for purposes of ERISA preemption. This conclusion is consistent not only with the words, but also the purposes of the statute. A converted policy is created when an ERISA plan participant leaves the plan and obtains a new, separate, individual policy based on conversion rights contained in the ERISA plan. The contract under the converted policy is directly between the insurer and the insured. It is independent of the

> ERISA plan and does not place any burdens on the plan administrator or the plan. There are also no relevant administrative actions by the employer. *See Fort Halifax*, 482 U.S. at 16 ("It would make no sense for preemption to clear the way for exclusive federal regulation, for there would be nothing to regulate.").

Id. at 875-76.

The First Circuit has also concluded that this Court's decision in *Fort Halifax* requires the conclusion that ERISA preemption cannot exist unless a state law claim impacts an employer's ongoing administration of an ERISA plan. *See Demars v. Cigna Corp.*, 173 F.3d 443 (1st Cir. 1999). In *Demars*, the plaintiff had converted coverage under a group disability policy to coverage under an individual policy after she ceased working for her employer. The First Circuit in *Demars* held that the plaintiff's claim under her individual policy was not preempted by ERISA. *Id.* at 450. The First Circuit in *Demars* reasoned that the congressional purpose of ERISA (protecting employers from conflicting state regulation) is not implicated in claims arising out of conversion coverages because they do not impact the employer's ongoing administration of an employee benefit plan.

> The uniformity of regulations concern [of ERISA] is equally attenuated. While conversion policies like Demars' undoubtedly impose an administrative burden, the burden lies on the insurers who provide the policy, not on the former employer. As [the Supreme Court in] *Fort Halifax* noted, 'Congress intended preemption to afford employers the advantages of a uniform set of administrative

> procedures governed by a single set of regulations. This concern only arises with respect to benefits whose provision by nature requires an ongoing administrative program to meet the employer's obligation'. Thus, an employee benefit may be considered a plan for purposes of ERISA only if it involves the undertaking of continuing administrative and financial obligations by the employer. Under this analysis, conversion policies are not ERISA plans because employers do not bear any administrative or financial responsibility for them.

Id. at 446 (citations omitted).

Like the Ninth Circuit in *Waks*, the First Circuit in *Demars* focused on this Court's decision in *Fort Halifax* to distill the principle underlying the "relate to" requirement of ERISA preemption.

> What matters for ERISA purposes is . . . the nature of employer's ongoing administrative and financial ties to the policy. If no such ties exist, the policy should not be subject to ERISA regulation.

Demars, 173 F.3d at 450. In the present case, as in *Waks* and *Demars*, Mr. Cooper's former employer had no administrative or financial ties to his insurance coverage at the time of the conduct giving rise to Mr. Cooper's state law claims. Rather, the administrative and financial burden of providing insurance coverage for Mr. Cooper's claim for benefits rested solely with Provident. There was no financial burden on Mr. Cooper's former employer because any benefits due

under the policy were owed by Provident. Moreover, there was no administrative burden on Mr. Cooper's former employer insofar as the employer had terminated its relationship with the purported employee benefit plan long before Provident reached its decision to deny Mr. Cooper's claim. Accordingly, because Mr. Cooper's employer had severed all ties to his disability insurance coverage prior to the time that Provident reached its determination to deny his claim, therefore, any state law claim for wrongful denial of benefits did not "relate to" the then defunct ERISA plan.

Conclusion

Rule 10 of the Supreme Court Rules sets forth the considerations governing review by way of certiorari. The rule is clear that a Petition for Writ of Certiorari will be granted only for compelling reasons. While these reasons include a decision by a United States Court of Appeals which conflicts with a decision of another circuit court, under the Ninth Circuit's rules, the court's memorandum decision in the present case is not binding authority on any person other than Mr. Cooper and Provident. Accordingly, the circuit court's decision cannot create any conflict with decisions of any other court. Moreover, because the memorandum decision is not applicable to any person other than Mr. Cooper and Provident, there is no compelling reason for this Court to exercise its discretionary review of this matter.

For the foregoing reasons, Respondent respectfully requests that this honorable Court deny the Petition for Writ of Certiorari.

Respectfully submitted,

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REPLY TO BRIEF IN OPPOSITION

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I. MR. COOPER ADMITS THAT THE NINTH CIRCUIT HAS ENTERED A DECISION WHICH CONFLICTS WITH THE DECISIONS OF THE SIXTH, EIGHTH AND ELEVENTH CIRCUITS.

Mr. Cooper predicates his Brief In Opposition almost exclusively upon the Ninth Circuit's decision in *Waks v. Empire Blue Cross/Blue Shield*, 263 F.3d 872 (9th Cir. 2001), which is the very decision that conflicts with the decisions of the Sixth, Eighth and Eleventh Circuits, and is the very decision upon which the Ninth Circuit predicated its erroneous ERISA preemption ruling here. Mr. Cooper therefore admits, without expressly saying so, that there now is an alarming and significant conflict among the Circuits as to whether ERISA continues to govern ongoing claims for ERISA benefits by former employees on post-employment insurance policies derived from their employer's ERISA Plan.

In fact, Mr. Cooper implicitly admits that the conflict among the Circuits is even greater than Provident first believed, because he cites to the First Circuit's decision in *Demars v. Cigna Corporation,* 173 F.3d 443 (1st Cir. 1999), which also conflicts with the decisions of the Sixth, Eighth and Eleventh Circuits.

Mr. Cooper does not dispute that ERISA is a federal statute of national application in which there is an overriding need for national uniformity. Mr. Cooper also does not dispute that this Court has repeatedly recognized this fundamental principle of ERISA law, and has done so as recently as a few months ago. *Rush Prudential HMO, Inc. v. Moran*, ___ U.S. ___ , No. 00-1021 (June 20, 2002); *Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41 (1987).

Given Mr. Cooper's implicit admissions and citation to an additional case which exacerbates the conflict among the Circuits on this important issue of ERISA preemption, the Court clearly should grant Provident's Petition, vacate the Ninth Circuit's Memorandum Decision and aberrant Decision in *Waks*, *supra*, and restore crucial uniformity to ERISA's application among the Circuits and throughout the United States.

II. MR. COOPER ADMITS THAT PROVIDENT'S PETITION PRESENTS AN ISSUE OF FIRST IMPRESSION REGARDING THE SCOPE OF ERISA PREEMPTION.

Mr. Cooper admits on page three of his Brief In Opposition that this Court has never before considered the ERISA preemption issue presented by Provident in its Petition.

Pursuant to *Massachusetts Casualty Insurance Company v. Reynolds*, 113 F.3d 1450 (6th Cir. 1997), millions of ERISA plan participants and beneficiaries throughout the Sixth Circuit are afforded the benefits and protections of ERISA, and correspondingly are subject to ERISA's expansive preemption clause.

Pursuant to *Painter v. Golden Rule Insurance Company*, 121 F.3d 436 (8th Cir. 1997), millions of ERISA plan participants and beneficiaries throughout the Eighth Circuit are afforded the benefits and protections of ERISA, and correspondingly are subject to ERISA's expansive preemption clause.

Pursuant to *Glass v. United of Omaha Life Insurance Company*, 33 F.3d 1341, 1347 (11th Cir. 1994), millions of

ERISA plan participants and beneficiaries throughout the Eleventh Circuit are afforded the benefits and protections of ERISA, and correspondingly are subject to ERISA's expansive preemption clause.

In stark contrast, pursuant to *Demars, supra,* and *Waks, supra,* millions of ERISA plan participants and beneficiaries throughout the First and Ninth Circuits are not afforded the benefits and protections of ERISA, and correspondingly are not subject to ERISA's expansive preemption clause.

Indeed, there is even a conflict **within** the Ninth Circuit as to whether millions of ERISA plan participants and beneficiaries are afforded the benefits and protections of ERISA when asserting claims for ERISA benefits on post-employment insurance policies derived from their employer's ERISA plan. In *Waks, supra,* the Ninth Circuit held that such ERISA plan participants and beneficiaries do not have the benefits and protections of ERISA, but in *Kearney v. Standard Insurance Company*, 175 F. 3d 1084, 1096, n. 1 (9th Cir. 1999), *cert. denied*, 120 S.Ct. 398 (1999), the Ninth Circuit held that such ERISA plan participants and beneficiaries **do** have the benefits and protections of ERISA.

This Court allowed the Ninth Circuit's decision in *Kearney, supra,* to stand when it denied certiorari in 1999, ostensibly because the *Kearney* decision was consistent with longstanding precedent on ERISA preemption from the Sixth, Eighth and Eleventh Circuits, and from the Ninth Circuit itself. *See Peterson v. American Life & Health Insurance Company*, 48 F.3d 404, 408 (9th Cir. 1995); *Qualls v. Blue Cross of California, Inc.*, 22 F.3d 839, 843 n.4 (9th Cir. 1994); *Greany v. Western Farm Bureau Life Insurance Company*, 973 F.2d 812, 817 (9th Cir. 1992); *Tingey v.*

Pixley-Richards West, Inc., 953 F.2d 1124, 1132-1133 (9th Cir. 1992). The Eighth Circuit expressly recognized this fact in *Painter, supra,* when it stated that its ERISA preemption decision "is consistent with the overwhelming majority of preemption decisions involving conversion policies and the ERISA plans which gave them birth", citing *Peterson, Greany* and *Reynolds, supra. Painter, supra* at 440.

This Court therefore should not allow the Ninth Circuit's subsequent contrary decision in *Waks, supra,* to stand, nor should it allow the Ninth Circuit's subsequent contrary decision on Mr. Cooper's claim to stand, since it is predicated exclusively upon the aberrant *Waks* decision, which is contrary to the *Kearney* decision and the decisions of the Sixth, Eighth and Eleventh Circuits, and contrary to the principal object of ERISA itself.

This Court has repeatedly held that "**[T]he principal object of [ERISA] is to protect plan participants and beneficiaries.**" *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company*, 514 U.S. 645, 657 (1995); *Boggs v. Boggs*, 520 U.S. 833, 845 (1997). The Ninth Circuit's decision, however, eviscerates the principal object of ERISA and strips the benefits and protections of ERISA from millions of ERISA plan participants and beneficiaries throughout the Ninth Circuit. The Court therefore should grant Provident's Petition given this compelling conflict among the Circuits.

III. MR. COOPER IGNORES THE EXPRESS PROVISIONS OF ERISA AND THE DECISIONS OF THIS COURT INTERPRETING ERISA.

The express provisions of 29 U.S.C. § 1002(1) clearly demonstrate that Congress intended ERISA to govern every

type of ERISA plan that either once "**was** established" or still "**is** maintained" by an employer. The change from past tense to present tense in such an unambiguous manner readily demonstrates that Congress intended ERISA to govern all claims for benefits derived from any type of ERISA plan that once "**was** established" by an employer, regardless of whether the ERISA plan continued to exist until the time of an insured's claim.

The express provisions of 29 U.S.C. § 1144(a) clearly demonstrate that Congress intended ERISA to "supersede any and all State laws insofar as they may now or hereafter relate to **any** employee benefit plan", regardless of whether the ERISA plan continued to exist until the time of an insured's claim.

Moreover, the express provisions of 29 U.S.C. § 1002(7) clearly demonstrate that Congress intended ERISA to continue to apply to all post-employment claims for ERISA benefits on policies derived from an ERISA Plan, regardless of whether the ERISA Plan continued to exist, because Congress defines an ERISA plan "participant" to include "any employee **or former employee** of an employer."

The only way a former employee could assert such a claim for benefits is if he had formally converted his ERISA plan benefits into an individual policy, or, like Mr. Cooper, had merely elected to continue coverage by paying the premiums himself upon termination of his employment. Therefore, Congress clearly contemplated the filing of claims for ERISA benefits by former employees on their post-employment policies derived from their employer's ERISA Plan, by formal conversion or by mere election of continued coverage, regardless of whether the employer's ERISA Plan

continued to exist until the time of the former employee's claim.

This Court has repeatedly recognized that ERISA specifically includes former employees within its definition of ERISA plan "participants", and that such ERISA plan participants are subject to ERISA with regard to all lawsuits brought by them for ERISA benefits. *See, Pilot Life Insurance Company v. Dedeaux*, 481 U.S. 41, 54 (1987); *Rush Prudential, supra*, citing *Pilot Life, supra* at 56. This Court has expressly held that "Congress' choice of language is significant" in determining the scope of ERISA preemption. *Fort Halifax Packing Company v. Coyne,* 482 U.S. 1, 8 (1987). Here, Congress' choice of language in §§ 1002(1), 1002(7) and 1144(a) is not only significant, it is dispositive.

Mr. Cooper's superficial reliance upon this Court's decision in *Fort Halifax, supra,* is misplaced, at best, because that case involved only the issue of whether ERISA preempted a state statute requiring the one-time payment of a severance benefit to laid-off workers, which clearly has nothing to do with the issue here: whether ERISA continues to govern ongoing claims for ERISA benefits by former employees on post-employment insurance policies derived from the employer's ERISA Plan.

Indeed, this Court expressly recognized in *Fort Halifax, supra,* that there is a fundamental difference between a statute which requires a one-time benefit payment and an ERISA plan which requires ongoing payments and ongoing ERISA fiduciary duties. *Fort Halifax, supra* at 12-14. In fact, whenever an ERISA plan provides for continued ERISA benefits for as long as the plan participant remains disabled, then the employer's and the insurer's ERISA fiduciary duties continue on and on, long after and notwithstanding the

intervening termination of the ERISA plan itself. Therefore, the continued existence of an ERISA plan is not a condition precedent to ERISA preemption. *Fort Halifax, supra.*

Mr. Cooper's allegation that his post-employment policy does not "relate to" his employer's ERISA plan is fundamentally flawed because he would have no relationship with Provident or cause of action against Provident without his employer's ERISA plan. This Court has expressly held that the words "relate to" should be construed expansively, and Mr. Cooper's attempt to construe this provision of ERISA as narrowly as possible flies in the face of this Court's precedent to the contrary. *See Fort Halifax, supra* at 8.

IV. MR. COOPER IGNORES THE EXPRESS PROVISIONS OF RULE 10 OF THIS COURT.

Rule 10(a), *U.S. Supreme Court Rules of Practice,* expressly provides that two compelling reasons for this Court's review are (1) a U.S. court of appeals has entered a decision in conflict with the decision of another U.S. court of appeals, and (2) a U.S. court of appeals has so far departed from the accepted and usual course of judicial proceedings as to call for an exercise of this Court's supervisory power.

Mr. Cooper admits in his Brief In Opposition that the Ninth Circuit has entered a decision which conflicts with the decisions of the Sixth, Eighth, Ninth and Eleventh Circuits. Provident's Petition therefore should be granted for this reason alone.

Contrary to Mr. Cooper's allegation, the memorandum nature of the Ninth Circuit's decision is irrelevant as a matter of law because it is predicated exclusively upon the Ninth Circuit's reported decision in

Waks, supra, which conflicts with the Ninth Circuit's *en banc* decision in *Kearney, supra,* and which conflicts with the decisions of the Sixth, Eighth and Eleventh Circuits as well.

Furthermore, Mr. Cooper already has improperly attempted to use the Ninth Circuit's memorandum decision against Provident in violation of Ninth Circuit Rule 36-3 in unrelated litigation within the Ninth Circuit. Indeed, according to Mr. Cooper, every Provident insured who sues Provident in the Sixth, Eighth, Ninth and Eleventh Circuits can use the Ninth Circuit's memorandum decision against Provident notwithstanding the contrary precedent in those Circuits, just like Mr. Cooper improperly attempted to do in Arizona notwithstanding the contrary Ninth Circuit precedent in *Kearney, supra.*

Therefore, it is disingenuous for Mr. Cooper to allege that there is no harm to Provident simply because the Ninth Circuit's decision is a memorandum decision. The harm is readily apparent if Mr. Cooper and other plaintiffs throughout the country can use the Ninth Circuit's memorandum decision as offensive collateral estoppel against Provident even in Circuits where there is longstanding judicial precedent to the contrary. Provident, like millions of other ERISA plan participants and beneficiaries, would not have the uniform benefits and protections of ERISA depending on which Circuit it found itself in as an ERISA defendant.

Mr. Cooper also ignores the second compelling reason under Rule 10(a) for this Court's review because the Ninth Circuit so far departed from the accepted and usual course of judicial proceedings that this Court's review is imperative.

The Ninth Circuit predicated its Memorandum Decision exclusively upon the material point of fact that the

ERISA plan terminated "before Cooper filed his claim" (App. 4a).

The Ninth Circuit's misstatement of this material point of fact contradicts the Rule 52 Findings of Fact by the District Court that Mr. Cooper had filed his claim for ERISA benefits on the Capin ERISA Plan **two months before** the Plan terminated, and that Mr. Cooper had sought ERISA benefits all the way back to March 1993, **over 2½ years before** the ERISA Plan terminated. Indeed, it is difficult to imagine how Mr. Cooper's claim could not be governed by ERISA, when he asserted a claim on an existing ERISA Plan for ERISA benefits going all the way back to over 2½ years before the ERISA Plan even terminated. This is exactly what Mr. Kearney did, which conclusively demonstrates how this particular panel ignored its own *en banc* decision in *Kearney, supra*, and erroneously perpetuated the conflict with the Sixth, Eighth and Eleventh Circuits by relying exclusively upon its aberrant Decision in *Waks, supra*, which had created the conflict one year earlier.

By knowingly predicating its decision on a material point of fact that contradicted outright the Rule 52 Findings of Fact of the District Court, the Ninth Circuit violated longstanding Ninth Circuit precedent on the applicable standard of review. *See L.K. Comstock & Company v. United Engineers & Constructors, Inc.*, 880 F.2d 219, 221 (9th Cir. 1989); *InterPetrol Bermuda, Ltd. v. Kaiser Aluminum International Corporation*, 719 F.2d 992, 998 (9th Cir. 1983).

CONCLUSION

The Ninth Circuit's memorandum decision perpetuates a significant conflict within the Ninth Circuit and among all the Circuits regarding how and when ERISA applies to post-

employment insurance policies derived from ERISA Plans. This conflict with the Sixth, Eighth and Eleventh Circuits, as well as within the Ninth Circuit itself, substantially and deleteriously affects ERISA, which clearly is a rule of national application in which there is an overriding need for national uniformity. The Ninth Circuit's decision also constitutes an alarming departure from the accepted and usual course of judicial proceedings.

Provident therefore respectfully requests the Court to take judicial notice of its own Rule 10(a), which expressly recognizes such conflicts and judicial error as compelling reasons for review, and respectfully requests the Court to grant Provident's Petition for a Writ of Certiorari, vacate the Ninth Circuit's memorandum decision and *Waks* decision, and thereby restore crucial uniformity to ERISA's application within the Ninth Circuit, among all the Circuits, and throughout the United States.

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